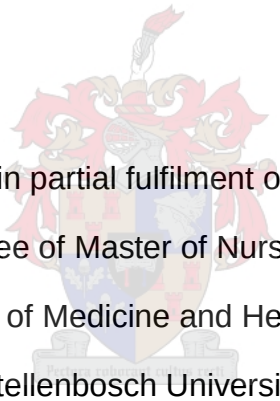
Exploring newly qualified nurses' experiences of their compulsory community service year at an urban district hospital

Vanessa Christina Scheepers



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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Date: March 2020

ABSTRACT

Background: Compulsory community service in the South African health sector was initiated by the National Department of Health with two distinct goals (Parker, Steyn, Mchiza, Wentzel-Viljoen, Dannhauser, Mbhenyane, Nthangeni & Moeng, 2011: 1412) firstly, to ensure improved delivery of health services to all South Africans; and secondly, to provide opportunities for newly qualified health professionals to develop their knowledge, practical skills, critical thinking abilities and professional behaviour (Hatcher, Onah, Kornik, Peacocke & Reid, 2014: 2). Despite the secondary goal (providing newly qualified health professionals with opportunities to develop their knowledge, practical skills, critical thinking abilities and professional behaviours), literature shows there are facilitators and barriers that seem to influence a person's experience of the community service year (Reid et al., 2018: 44-45; Netshisaulu & Maputle, 2018: 4-6). It seems that, similarly to the experiences of other healthcare professionals, nurses engaged in community service at the public health facility where the researcher is employed do not seem to benefit from this stated secondary goal. The purpose of this study was therefore to explore and describe newly qualified nurses' experiences of the compulsory community service year at an urban district hospital.

Methods: A qualitative approach with an exploratory, descriptive research design was used for the study. A purposive sampling method was applied, and the final study sample comprised of five participants out of the 13 community service nurses. A semi-structured interview guide was used to collect narrative data from participants and field notes were made. Qualitative content analysis was used to analyze the data collected.

Results: Three overarching themes and eight sub-themes emerged through the data analysis process. The first theme, *a complex experience*, described the varied experiences of the participants during their compulsory community service year. The second theme, *support*, highlighted participants' experience of the support they had received. The third theme, *on the floor*, described the positive experiences and challenges the participants encountered in the clinical environment.

Conclusion: The research question of this study was answered through an analysis of the participants' rich, in-depth experiences. Community service nurses had varied

experiences of the community service year. The overall experience was positive, with community service nurses being able to develop their knowledge, practical skills, critical thinking abilities and professional behaviour. Their experiences identified specific facilitators and barriers that influence newly qualified nurses' experience of the community service year. This understanding can inform a review and revision of the current support strategies for newly qualified nurses doing compulsory community service in public urban hospitals.

Keywords: community service, compulsory, experiences, perceptions, novice nurses, newly qualified nurses, graduates, role transition

OPSOMMING

Agtergrond: Verpligte gemeenskapsdiens in die Suid-Afrikaanse gesondheidsektor is deur die Nasionale Departement van Gesondheid met twee afsonderlike doelstellings geïnisieer (Parker, Steyn, Mchiza, Wentzel-Viljoen, Dannhauser, Mbhenyane, Nthangeni & Moeng, 2011: 1412): eerstens, om verbeterde lewering van gesondheidsdienste aan alle Suid-Afrikaners te verseker; en tweedens, om geleenthede aan pas-gekwalifiseerde gesondheidswerkers te bied om hul kennis, praktiese vaardighede, kritiese denkvaardighede en professionele gedrag te ontwikkel (Hatcher, Onah, Kornik, Peacocke & Reid, 2014: 2). Ten spyte van die sekondêre doel (om aan pas-gekwalifiseerde gesondheidswerkers geleenthede te bied om hul kennis, praktiese vaardighede, kritiese denkvermoë en professionele gedrag te ontwikkel), toon die literatuur dat daar fasiliteerders en hindernisse is wat blykbaar die persoon se ervaring van die gemeenskapsdiensjaar beïnvloed (Reid et al., 2018: 44-45; Netshisaulu & Maputle, 2018: 4-6). Dit wil voorkom asof verpleegkundiges wat betrokke is by gemeenskapsdiens by die openbare gesondheidsorgfasiliteit waar die navorser werksaam is, net soos ander gesondheidsorgkundiges, nie baat by hierdie vermelde sekondêre doel nie. Die doel van hierdie studie was dus om pas-gekwalifiseerde verpleegkundiges se ervarings van die verpligte gemeenskapsdiensjaar in 'n stedelike distrikshospitaal te verken en te beskryf.

Metodes: 'n Kwalitatiewe benadering met 'n verkennende, beskrywende navorsingsontwerp is vir die studie gebruik. 'n Doelgerigte steekproefmetode is toegepas, en die finale studie steekproef het uit vyf deelnemers uit die 13 gemeenskapsdiensverpleegkundiges bestaan. 'n Semi-gestruktureerde onderhoudsgids is gebruik om narratiewe data van deelnemers in te win en veldnotas is gemaak. Kwalitatiewe inhoudsanalise is gebruik om die ingewinde data te ontleed.

Bevindinge: Drie oorkoepelende temas en agt subtemas het na vore gekom deur die proses van data-ontleding. Die eerste tema, *'n ingewikkelde ervaring*, het die uiteenlopende ervarings van die deelnemers tydens hul verpligte gemeenskapsdiensjaar beskryf. Die tweede tema, *ondersteuning*, het die deelnemers se ervaring van die ondersteuning wat hulle ontvang het, beklemtoon. Die derde tema, *op die vloer*, het die positiewe ervarings en uitdagings wat die deelnemers in die kliniese omgewing teëgekom het, beskryf.

Slotsom: Die navorsingsvraag van hierdie studie is beantwoord deur die analise van die ryk, diepgaande ervarings van die deelnemers. Gemeenskapsdiensverpleegkundiges het uiteenlopende ervarings van die gemeenskapsdiensjaar gehad. Die algemene ervaring was positief, aangesien gemeenskapsdiensverpleegkundiges hulle kennis, praktiese vaardighede, kritiese denkvaardighede en professionele gedrag kon ontwikkel. Hul ervarings het spesifieke fasiliteerders en hindernisse geïdentifiseer wat pas-gekwalifiseerde verpleegkundiges se ervaring van die gemeenskapsdiensjaar beïnvloed. Hierdie insig kan 'n oorsig en hersiening van die huidige ondersteuningstrategieë vir pas-gekwalifiseerde verpleegkundiges wat verpligte gemeenskapsdiens in openbare stedelike hospitale doen, inlig.

Sleutelwoorde: gemeenskapsdiens, verpligtend, ervarings, persepsies, beginnersverpleegkundiges, pas-gekwalifiseerde verpleegkundiges, gegradueerdes, roloorgang

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None but ourselves can free our minds (Robert Nesta Marley)

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ABBREVIATIONS

EAP	Employee Assistance Programme
ENA	Enrolled nursing auxiliary
EN	Enrolled nurse/ staff nurse
HREC	Health Research Ethics Committee
RN/ PN	Registered nurse/ professional nurse
IV	Intravenous
SANC	South African Nursing Council
NEI	Nursing education institution

CHAPTER 1
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Compulsory community service is a programme that allocates healthcare professionals to underserved public health facilities to provide their respective services for a specific time (Reid, Peacocke, Kornik & Wolvaardt, 2018: 741). This type of programme has been implemented in more than 70 countries worldwide (Frehywot, Mullan, Payne & Ross, 2010: 364). Frehywot et al. (2010: 364-370) have identified three different types of compulsory service programmes in various countries: the first type being a condition of service or state employment programme, where health professionals are required to work for the government. The second type is compulsory service with incentives, meaning that health professionals are provided with incentives to serve in a specific area for a designated period (Frehywot et al., 2010: 365), while the third type is compulsory service without incentives (Frehywot et al., 2010: 366). In South Africa, compulsory service with incentives is the norm, as community service is a prerequisite to registering and obtaining licensure to practice in each health discipline (Reid et al., 2018: 741-742).

Compulsory community service for health practitioners in South Africa was legislated in the Medical, Dental and Supplementary Health Service Professions Amendment Act No. 89 of 1997 (Republic of South Africa, 1997: 20) and was initiated by the National Department of Health in 1998 (Parker et al., 2011: 1412). Community service comprises one-year placement at public urban and rural clinical facilities (Reid et al., 2018: 741).

The National Department of Health's overarching purpose and intention of compulsory community service is to ensure improved delivery of health services to all South Africans (Reid et al., 2018: 741). Within this overarching purpose, the secondary purpose and intention of compulsory community service is to provide opportunities for health professionals to develop their knowledge, practical skills, critical thinking abilities and professional behaviours (Reid et al., 2018: 741; Hatcher et al., 2014: 2). The secondary purpose of community service can be aligned with the phase of transition for newly graduated health professionals as they adapt to their new roles

and responsibilities (Govender, Brysiewicz & Bhengu, 2017: 14-15). The community service year can therefore be viewed as a period of transition for newly graduated health professionals (Roziers, Kyriacos & Ramugondo, 2014: 91; Govender et al., 2017: 14-15). Community service may support a person in their transition from a student role to neophyte professional.

Doctors were the first to begin with compulsory community service in 1998. They were later followed by other health professionals, including dentists, pharmacists, physiotherapists, occupational and speech therapists, clinical psychologists, dietitians, radiographers, environmental health practitioners and, finally, nurses and midwives in January 2008 (Hatcher et al., 2014: 2; Govender, Brysiewicz & Bhengu, 2015: 1). Community service for nurses was legislated in the Nursing Act No. 33 of 2005 (Republic of South Africa, 2006: 40). The community service year is only applicable to graduates who are South African citizens and have completed a four-year nursing programme that leads to registration at the South African Nursing Council (SANC) as per Regulation 425 of February 1985 (South African Nursing Council, 1985: 1; South African Nursing Council, 2007: 1). These graduates then register as community service nurses for one year with the SANC (Republic of South Africa, 2006: 40; South African Nursing Council, 2007: 1). Successful completion of the four-year nursing programme, followed by one year of community service, currently permits registration in general nursing, midwifery, psychiatry and community nursing with the SANC (Republic of South Africa, 2006: 34-42; South African Nursing Council, 2007: 1).

While the secondary purpose of community service is to provide newly graduated health professionals with opportunities to develop their knowledge, practical skills, critical thinking abilities and professional behaviours, health professionals still seem to lack clinical competencies and skills relating to attitude, teamwork, confidence and communication at the end of the community service year (Reid et al., 2018: 44-45; Netshisaulu & Maputle, 2018: 4-6). Literature further shows that there are facilitators and barriers that seem to influence a person's experience of the community service year, such as clinical support, orientation, practical experience and collegial relationships.

Based on my observation in clinical practice environments of an urban district hospital, it seemed that nurses engaged in community service at the public health facility

similarly did not seem to achieve the stated secondary purpose of developing their knowledge, practical skills, critical thinking abilities and professional behaviours. This observation is concerning, as healthcare in South Africa rests on competent, safe and professional nursing practitioners as nurses constitute the majority of health care professionals in this country (Morolong & Chabeli, 2005: 38; Thopola, Kgole & Mamogobo, 2013: 170).

1.2 RATIONALE

As a nursing manager employed at an urban district public health institution, I observed that despite strategies in place to support community service nurses in achieving the secondary purpose and intent of community service, many seemed to experience difficulty in developing their knowledge, skills and attitudes during the compulsory year.

Although these community service nurses were supported through structured orientation and induction programmes, clinical rotations and exposure to practical skills pertinent to their placement areas during the year, some of these nurses demonstrated deficits relating to knowledge, practical skills and critical thinking abilities once they had completed the year. An example of this is that of a newly qualified registered nurse who, after completion of the compulsory community service year, failed to identify the early signs and symptoms of shock in a patient. The outcome was that the patient required emergency interventions and surgery to manage the consequences of uncontrolled bleeding. In addition, incidents have been reported where some newly qualified registered nurses displayed unprofessional and undesirable behaviours towards patients, family, colleagues and supervisors.

While the success of compulsory community service for other healthcare professionals had been investigated (Hatcher et al., 2014: 1-14; Pillay & Harvey, 2006: 259-280; Reid et al., 2018: 741-747), there is little research regarding the success of community service for nurses in South Africa.

1.3 PROBLEM STATEMENT

Despite various strategies instituted to support newly graduated nurses placed in public urban hospitals for the community service year, observations and reported

negative care related incidents call into question whether the secondary purpose of community service is being achieved by newly qualified nursing graduates during this compulsory service year.

Through engaging with the nurses who had recently experienced the community service year, an understanding of their experiences assisted in identifying the components of the community service year that contributed to as well as detracted from them developing their knowledge, practical skills, critical thinking abilities and professional behaviours. This understanding can inform a review and revision of the current support strategies for newly qualified nurses doing community service in public urban hospitals.

1.4 RESEARCH QUESTION

What are the experiences of newly qualified nurses during the compulsory community service year at an urban district hospital?

1.5 RESEARCH AIM

The aim of this study was to explore and describe newly qualified nurses' experiences of compulsory community service year at an urban district hospital.

1.6 RESEARCH OBJECTIVES

The objectives of this study were to:

- explore newly qualified nurses' experiences of community service
- describe these experiences in relation to knowledge, practical skills, critical thinking abilities and professional behaviour development
- identify facilitators and barriers that influence the development of knowledge, practical skills, critical thinking abilities and professional behaviours in a newly qualified nurse during the community service year

1.7 RESEARCH METHODOLOGY

A brief description of the research methodology is provided in this section, while a more detailed description of the methodology is provided in Chapter 3 of this thesis.

1.7.1 Research design

A qualitative, exploratory, descriptive research design (Gray, Grove & Sutherland, 2017: 133) was followed in this study as the researcher wished to explore and describe newly qualified nurses' experiences of their community service year at an urban district hospital.

1.7.2 Study setting

The study was conducted in the Southern Peninsula Health District of the Metro Region of the Western Cape at a Cape Town urban district hospital. The urban district hospital, located in the southern suburbs of Cape Town, provides health services to the poorer communities who experience a heavy burden of disease (Western Cape Department of Health, 2005: 3-6).

1.7.3 Population and sampling

The study population included all registered community service nurses working at the district hospital who had completed a four-year nursing programme as per the SANC (Republic of South Africa, 2007: 46-49). A purposive sampling method was applied. The final study sample comprised of five participants out of the 13 community service nurses.

1.7.4 Pilot interview

A pilot interview was conducted before the main study to determine any flaws in the semi-structured interview guide and feasibility of the study (Gray et al., 2017: 628; Brink, Van der Walt & Van Rensburg, 2018: 161). One participant of the study sample was selected from the urban district hospital to participate in the pilot interview. Data collected by the researcher during the pilot interview was included in the main study as no changes were required to the format and content of the interview guide.

1.7.5 Trustworthiness

Trustworthiness in this study was ensured by applying the four criteria of credibility, transferability, dependability and confirmability to underpin the rigour of this work (Polit & Beck, 2018: 295-296; Grove, Gray & Burns, 2015: 68).

1.7.6 Data collection

A semi-structured interview guide was used to collect narrative data (Brink et al., 2018: 144-145). The interview guide served to elicit data from the participants regarding their experiences of the compulsory community service year at an urban district hospital. Participants in this study were offered the option to provide either verbal or written data. None of the participants opted to write naïve sketches.

1.7.7 Data analysis

Qualitative content analysis was used to analyze the data collected during the interviews (Erlingsson & Brysiewicz, 2017: 93-99; Bengtsson, 2016: 10).

1.8 ETHICAL CONSIDERATIONS

Ethical approval to conduct the research study was obtained from the Health Research Ethics Committee of Stellenbosch University (HREC) (S17/02/031) (see Appendices 1 & 2). In addition, permission to conduct the study at the urban district hospital was obtained from the Western Cape Health Department (WC_2017RP35_863) (see Appendix 3) and the Head of Medicine of the institution (see Appendix 4).

The study was guided by three key ethical principles, namely respect for individuals, beneficence and justice (Brink et al., 2018: 29). These ethical principles are based on the human rights of self-determination, privacy, anonymity, confidentiality, fair treatment, and protection from discomfort and harm (Brink et al., 2018: 31-35). The researcher of this study complied with these ethical principles, as discussed below.

1.8.1 Right to self-determination

The principle of respect for individuals means that the participants' right to autonomy must be ensured (Brink et al., 2018: 29). In this study, the researcher explained to the participants that their participation in this study was voluntary. Furthermore, the researcher informed the participants that they had the right to withdraw from the study at any point. In addition, the participants were informed that they had the right to refuse to provide information.

Informed consent was obtained during information sessions held with participants where an adapted version of Stellenbosch University's HREC participant information leaflet and informed consent form (see Appendix 5) was distributed and explained in

detail. The study participants were given the opportunity to discuss any queries that they had about the study and informed consent forms (Brink et al., 2018: 29). The information leaflets and informed consent forms were available in English, Afrikaans and isiXhosa. The Afrikaans and isiXhosa versions of the information leaflets and informed consent forms were translated by Stellenbosch University's language centre (see Appendix 6). All participants provided verbal consent for their interviews to be voice recorded.

1.8.2 Right to confidentiality and anonymity

Confidentiality and anonymity involve keeping all the information provided by participants private and anonymous (Brink et al., 2018: 30-31). In this study, the researcher ensured that data could only be accessed by those people who were directly involved with the study. The name of the hospital and the participants were not disclosed. Code names were used to ensure anonymity of all participants during data collection, analysis and after the report was written. In addition, all the data collected, and transcriptions thereof were kept in a locked computer and hard copies thereof in a locked storage box.

1.8.3 Right to protection from discomfort and harm

The principle of beneficence was upheld by ensuring participants' right to be protected from discomfort and harm (Brink et al., 2018: 29). In this study, it was anticipated that participants might share sensitive or traumatic experiences. Therefore, participants were asked before the start of the interviews to provide contact details of someone who could be contacted should the need arise. The researcher informed participants before commencement of the interviews that they could be referred to the government's employee assistance programme if needed. Participants at the study setting who did not feel comfortable in sharing information of their community service year experiences with an outsider were provided with an option to write naïve sketches in an effort to ease feelings of discomfort.

1.9 OPERATIONAL DEFINITIONS

Nurse: In terms of the Nursing Act No. 33 of 2005, a nurse is a person registered in a category under section 31(1) in order to practice nursing or midwifery (Republic of South Africa, 2006: 6). In this study, a nurse refers to a professional nurse and midwife.

Newly qualified: Newly qualified refers to novice, neophyte or newly graduated professionals (Roziers et al., 2014: 91-100; Hatcher et al., 2014: 1-14; Hofler & Thomas, 2016: 133-136).

Community service nurse: This term refers to a nurse who had successfully completed a four-year nursing programme that allows for registration in general nursing, midwifery, psychiatry and community with the SANC (Republic of South Africa, 2006: 34-42; South African Nursing Council, 2007: 1) and has registered to perform community service for the first time.

Compulsory community service: A South African citizen who intends to register in a profession in a prescribed category for the first time, must perform remunerated community service for a period of one year at a public health facility (Republic of South Africa, 2006: 40; South African Nursing Council, 2007: 1).

Public health facility: A health establishment that is owned or controlled by an organ of state (Republic of South Africa, 2004: 16). In this study, a public hospital is a health establishment which is classified as such by the Minister in terms of Section 35 of the National Health Act, No. 61 of 2003 (Republic of South Africa, 2004: 12).

District hospital: A hospital which receives referrals from and provides generalist support to clinics and community health centres with health treatment administered by general health care practitioners or primary health care nurses (KwaZulu-Natal Department of Health, 2001).

Role transition: Refers to the role change from being a student to a practicing healthcare professional (Phillips et al., 2013: 106-107).

Transition shock: Refers to the disconnect experienced between academia and the clinical practice environment by newly qualified nurses when transitioning from student to practicing professional (Duchscher, 2009: 1105).

1.10 DURATION OF THE STUDY

The initial ethical approval (S17/02/031) from Stellenbosch University's ethics committee to conduct the study was obtained for 23 March 2017 until 22 March 2018

(see Appendix 1). A progress report was submitted to the ethics committee and further approval was granted for the period 18 December 2018 to 17 December 2019 (see Appendix 2). Permission to conduct the research was obtained from the Western Cape Department of Health (WC_2017RP35_863) on 24 May 2017 (see Appendix 3). Data was collected from July 2017 to August 2017 at hospital A. The data collected at hospital A was analyzed from March 2019 to July 2019. The final thesis was submitted on the 1st of December 2019 for examination.

1.11 CHAPTER OUTLINE

Chapter 1: Foundation of the study

This chapter provided the background and motivation of the study and also include the research question, aim, objectives, methodology, ethical considerations, operational definitions, duration of the study, outline of the chapters and the significance of the study.

Chapter 2: Literature review

Chapter 2 provides recent theoretical and scientific knowledge about the topic of newly qualified nurses' experiences of their first year post-graduation.

Chapter 3: Research methodology

Chapter 3 contains a more detailed description of the research methodology.

Chapter 4: Results

In this chapter, the results of the study are presented.

Chapter 5: Discussion, conclusions and recommendations

In Chapter 5, the results of the study are discussed, valid conclusions drawn and recommendations made.

1.12 SIGNIFICANCE OF THE STUDY

The findings of this research can be used to inform any revision of existing policies and strategies that are in place to guide professional practice and specific interventions aimed at ensuring the successful transitioning of newly qualified nurses into practice.

1.13 CONCLUSION

With nurses being the majority group of healthcare professionals in this country, healthcare in South Africa rests on competent, safe and professional nursing practitioners. The development of a competent professional group begins in effective community service, which entails adequate orientation, supervision, support and available resources. Therefore, it was imperative to understand the newly qualified nurses' experiences of their community service year in relation to the goal of developing their knowledge, practical skills, critical thinking abilities and professional behaviours.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

In Chapter 1, an outline of the study was presented. In this chapter, relevant literature was reviewed, and what is already known about newly qualified nurses' experiences of their compulsory community service year was described (Lobiondo-Wood & Haber, 2014: 99). The literature review places the current study in the context of the general body of knowledge (Brink et al., 2018: 58).

2.2 SELECTING AND REVIEWING THE LITERATURE

The databases included in this literature review were PubMed, Cumulative Index to Nursing and Allied Health Literature, Research Gate, SABINET, ScienceDirect and Google search engines, as well as the reference lists of pertinent published literature, for example articles relating to community service. The SANC's website was searched for documents and reports relevant to community service to include in this literature review.

The search parameters were focussed to find relevant published literature of the last ten years, and only significant articles older than ten years were included. The key words used for the search were: community service, compulsory, mandatory, experiences, perceptions, novice nurses, newly qualified nurses, graduates and role transition. The search yielded numerous international and South African studies, and the most relevant articles relating to the research question were selected for the literature review. Relevant literature included articles about compulsory community service, newly graduated or qualified health professionals' experiences during their first year of clinical practice and role transition experiences within the first year after graduation.

2.3 BACKGROUND

The secondary purpose of the community service year is that it should support a period of transition for newly graduated health professionals (Roziers et al., 2014: 91;

Govender et al., 2017: 14-15). This year is intended to assist health professionals in adapting to their new roles and responsibilities while gaining additional knowledge and practical skills and developing critical thinking abilities and professional behaviour (Parker et al., 2011: 1413-1414). The Oxford English Dictionary Online (2018) defines transition as moving from one state or condition to another. In the healthcare context, it refers to the change from being a student to becoming an independently working healthcare professional (Phillips, Kenny, Esterman & Smith, 2013: 106-107).

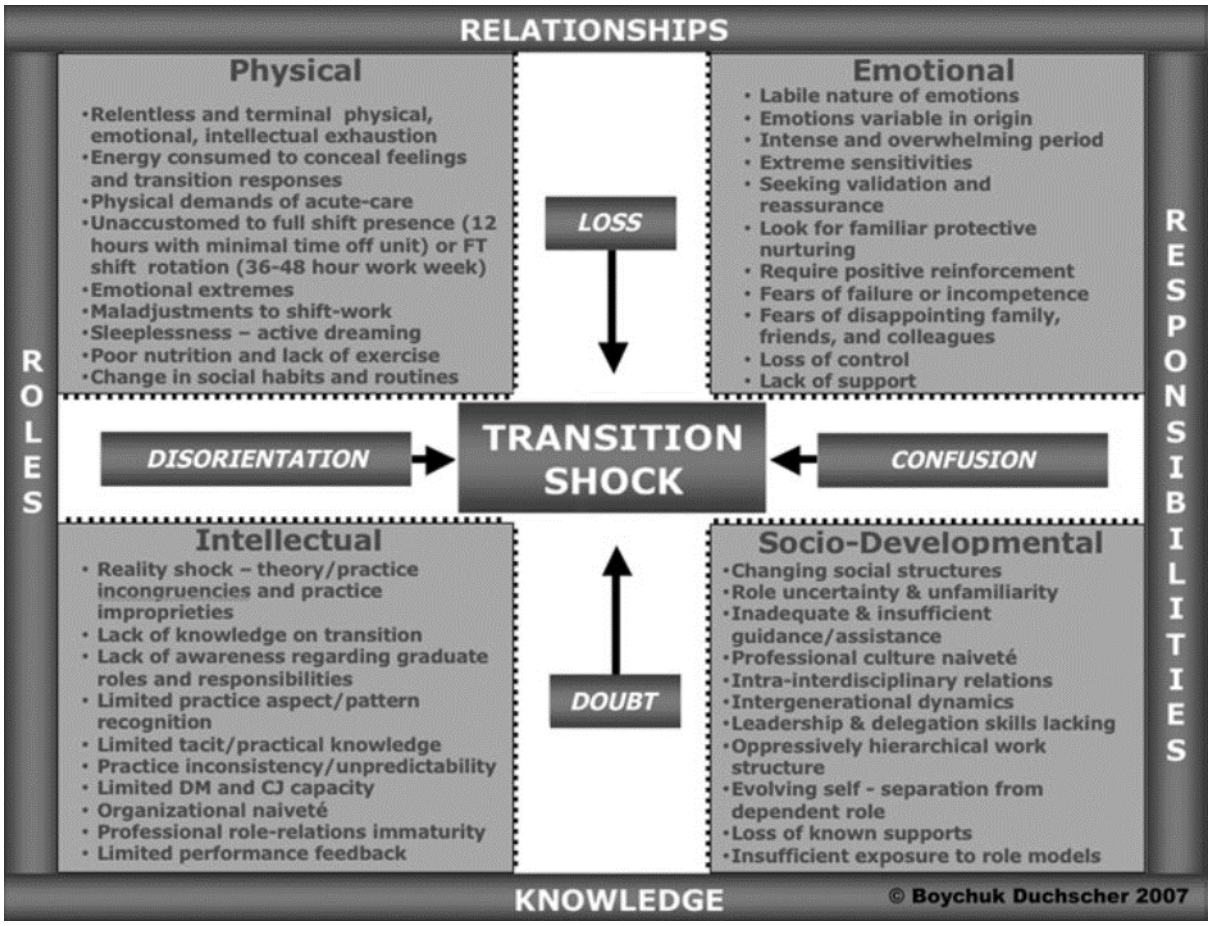
In the beginning of their community service year, newly graduated health professionals must adapt from academic and student life to the clinical practice environment at healthcare facilities (Govender et al., 2017: 14-15). During this role transition from student to practicing professional, many novice health graduates experience a disconnect between undergraduate training expectations and the practice environment in their community service year (Ankers, Barton & Parry, 2017: 322; Govender et al., 2017: 15). This disconnect between academia and practice is referred to as reality or transition shock (Kramer, 1974: 1-249; Duchscher, 2009: 1105). The transition shock theory was developed by Duchscher (2009: 1103-1113) to describe the initial stages of role transition of new graduates from student to working healthcare professionals.

2.3.1 Conceptual framework: Duchscher's transition shock theory

A conceptual framework assists in developing a study and links the findings to nursing's body of knowledge (Lobiondo-Wood & Haber, 2014: 238). Duchscher's (2009: 1103-1113) transition shock theory was used as the conceptual framework for this literature review. Duchscher's transition shock theory builds on the seminal work of Kramer (1974: 1-249). The phrase "reality shock" was created by Marlene Kramer (1974: 1-249) and describes nurses' experience of the role transition from being a nursing student to a practicing professional. The reality shock theory showed that nursing school values conflicted with professional practice values (Kramer, 1974: 1-249). Value conflicts are evident when newly qualified nurses describe their expectations of what they thought nursing to be as opposed to the reality that newly qualified nurses face in the working environment (Roziers et al., 2014: 96-97; Ankers et al., 2017: 322).

According to Duchscher's transition shock theory, newly qualified nurses assuming a professional practice role for the first time are faced with a wide-ranging scope of emotional, physical, intellectual, developmental and sociocultural changes that are both expressions of and extenuating aspects within the transition experience (Duchscher, 2009: 1103-1113; Duchscher & Windey, 2018: 228).

Figure 2.1 Duchscher's Transition Conceptual Framework



The literature review was organized using the factors describing role transition experiences of newly qualified nurses in Duchscher's (2009: 1107) conceptual framework, including scholarship related to community service. These factors include the emotional, physical, intellectual and socio-developmental changes that newly qualified nurses experience during role transition (Duchscher & Windey, 2018: 228). The emotional changes experienced by newly qualified nurses were divided further into sub-headings to include a lack of support; lack of practical experience and confidence; tense interpersonal relationships; loss of control over executing professional practice values and roles; exhaustion; and impractical performance expectations (Duchscher, 2009: 1105-1109).

2.4 EMOTIONAL CHANGES

During the first stage of role transitioning, as described in Duchscher's theory, newly qualified nurses experience intense and overwhelming emotions (Duchscher, 2009: 1106). High levels of stress and anxiety are prevalent during the first four months after orientation (Duchscher, 2009: 1106). Emotions such as feeling scared, terrified and shocked are experienced by the nurses in the first weeks of transitioning into clinical practice (Duchscher, 2009: 1106; Morales, 2013: 1295).

Similarly, in studies related to community service these findings can be seen in Du Plessis (2012: 4-6); Thopola et al. (2013: 173); Roziers et al. (2014: 95-96) and Abiodun, Daniels, Pimmer & Chipps (2019: 8) where newly qualified community service nurses also experienced bewilderment, doubt, fear and shock in the clinical area. Specific barriers to successful transitioning identified in the Transition Shock Theory are a lack of support, practical experience and confidence; tense interpersonal relationships; loss of control over executing professional practice values and roles; exhaustion and impractical performance expectations by health establishments, co-workers and newly qualified nurses themselves (Duchscher, 2009: 1106). These barriers will be discussed in more detail below.

2.4.1 Lack of support

Support for newly qualified professionals has been identified in numerous studies across professions to being essential for successful transitioning into practice (Abiodun et al., 2019: 9-10; Matlhaba, Pienaar & Sehularo, 2019: 4; Khunou, 2019: 6-12; Dlamini, Sekoli & Bresser, 2019: 112; Edwards, Hawker, Carrier & Rees, 2015: 1267; Missen, McKenna & Beauchamp, 2014: 2430; Parker et al., 2011: 1411-1418; Thopola et al., 2013: 169-181; Hatcher et al., 2014: 1-14; Govender et al., 2015: 1-8). However, newly qualified nurses report experiencing a loss of support systems formed during their undergraduate years as access to educators and peers become limited (Duchscher, 2009: 1107). Social support is essential for the successful transitioning of newly qualified nurses to the practice environment (Flinkman & Salantera, 2014: 1055). Interaction with peers in the units, with newly qualified nurses getting to share experiences and know each other better, are valued and has a positive effect on their daily work (Thrysoe, Hounsgaard, Dohn & Wagner, 2011: 554-555; Matlhaba et al., 2019: 4).

Furthermore, newly qualified nurses seek validation, reassurance, protective nurturing and positive reinforcement from colleagues (Duchscher, 2009: 1106-1107). A specific challenge which seem to have a negative influence on newly qualified nurses' confidence levels has been identified as difficult collegial relationships (Duchscher, 2009: 1106-1107). Likewise, in studies about community service nurses, the more experienced nurses are in part responsible for the socialization of newly qualified nurses, but the way some experienced nurses behave towards others and the newly qualified nurses negatively affect this professional socialization (Du Plessis, 2012: 22-35; Thopola et al., 2013: 177; Roziers et al., 2014: 96; Khunou, 2019: 10; Abiodun et al., 2019: 9).

Professional socialization involves learning the norms, attitudes, behaviours, skills, roles and values of a profession (Kuan Lai & Hong Lim, 2012: 32). It includes internalizing the values and norms of a profession in a person's own behaviour and self-concept (Kuan Lai & Hong Lim, 2012: 32). Unsupportive workplace conditions such as rejection by ward staff (Thopola et al., 2013: 177), isolation from experienced nursing teams (Khunou, 2019: 6) and bullying by experienced nurses (Abiodun et al., 2019: 9; Hofler & Thomas, 2016: 134) influence professional socialization of newly qualified nurses negatively. Additionally, negative workplace conditions are barriers to community service nurses' successful transitioning to the work environment as the experience of reality shock is increased (Roziers et al., 2014: 97).

Good support and acceptance by senior colleagues have a positive effect on newly qualified professionals' transitioning experience (Duchscher, 2009: 1106). This is evident in studies conducted by Philips et al. (2013: 108-110) and Craig, Moscato & Moyce (2012: 207) who identified key indicators to successful transitioning for newly qualified nurses. Key indicators include respect from senior colleagues, performance feedback and recognition of good work performance (Philips et al., 2013: 108-110). Furthermore, positive feedback, development of self-confidence and being accepted as part of the nursing team are critical indicators for successful transitioning (Craig et al., 2012: 207). Also, mutual professional and social interaction with colleagues enhance the experience of being valued and accepted as part of the work community (Thrysoe et al., 2011: 555).

In South Africa, many community service nurses describe their community service year as being rewarding because they felt supported (Matlhaba et al., 2019: 4; Roziers

et al., 2014: 95; Du Plessis, 2012: 15-20; Govender et al., 2015: 7), protected and appreciated by staff (Van Rooyen, Jordan, Ten Ham-Baloyi & Caka, 2018: 39; Du Plessis, 2012: 15-20). Positive feedback, acknowledgement from staff (Roziers et al., 2014: 95-96) and being treated as peers and colleagues (Du Plessis, 2012: 17-19) enhanced the transition experiences of community service nurses. Additionally, working with peers and seniors contributes to community service nurses' general learning experience (Matlhaba et al., 2019: 4; Parker et al., 2011: 1413).

2.4.2 Lack of practical experience and confidence

Newly qualified nurses fear rejection by colleagues and peers if they were to be exposed as being incompetent, unsafe practitioners unable to cope with their roles and responsibilities (Duchscher, 2009: 1107). Newly qualified nurses commence their first year of practice with basic knowledge and skills learned during their training (McCalla-Graham & De Gagne, 2014: 124-125). However, most newly qualified nurses are challenged beyond their beginning skill set due to inappropriate clinical rotations (Philips et al., 2013: 108-110), staff shortages and unfair duty rosters (Hofler & Thomas, 2016: 133; Flinkman & Salantera, 2014: 1053; Roziers et al., 2014: 96), inadequate staffing skill mixes (Phillips et al., 2013: 108), increased workloads (Abiodun et al., 2019: 8-9; Hofler & Thomas, 2016: 133; Flinkman & Salantera, 2014: 1055) and role conflict (Roziers et al., 2014: 95-96; Govender et al., 2015: 5).

Newly qualified nurses, equipped with limited clinical experience, have to make decisions, which could be extremely stressful (Khunou, 2019: 12; McCalla-Graham & De Gagne, 2014: 125). Furthermore, a lack of respect from colleagues undermine their practice and confidence (Philips et al., 2013: 109). Most community service nurses feel unprepared for the heavy responsibility given to them and as a result have low self-confidence (Govender et al., 2017: 18). However, newly qualified nurses who feel confident about their clinical competence display less work stress than those who are not confident in their clinical competence (Cheng, Liou, Tsai & Chang, 2014: 413; Khunou, 2019: 12).

Newly qualified nurses in their community service year are exposed to different work environments every time they are rotated through various clinical areas. Clinical rotation is crucial for developing newly qualified nurses' competence, knowledge and clinical skills (Matlhaba et al., 2019: 6). However, each clinical rotation increases the

reality shock experienced by newly qualified nurses as they have to deal with renewed anxiety and stress (Roziers et al., 2014: 97).

Furthermore, community service nurses are placed in public health facilities, which already have limited nursing staff (Govender et al., 2015: 1; Roziers et al., 2014: 92). The high number of patients in relation to nurses are an added stressor, as newly qualified nurses are generally not exposed to providing nursing care to a large number of patients during their student years (Abiodun et al., 2019: 8-9). In addition, staff shortages increase the nursing workload, and newly qualified nurses in their community service year feel overwhelmed as they find themselves having to be in charge of the wards (Roziers et al., 2014: 97; Govender et al., 2015: 5).

The change from being a student to being in charge of a ward can elicit further stress in newly qualified nurses as expectations in the new role are different (Parker, Giles, Lantry & McMillan, 2012: 152; Roziers et al., 2014: 95-96). Community service nurses often have to assume professional responsibilities that are beyond their capabilities, which intensifies the experience of reality shock and role transition (Flinkman & Salantera, 2014: 1054; Govender et al., 2015: 5-8; Matlhaba et al., 2019: 5; Khunou, 2019: 7).

2.4.3 Tense interpersonal relationships

Some newly qualified nurses feel insecure when communicating and interacting with new colleagues (Duchscher, 2009: 1106). Most newly qualified nurses report experiencing communication challenges with doctors and senior nurses (Theisen & Sandau, 2013: 408; Du Plessis, 2012: 36; Abiodun et al., 2019: 9). Additionally, many young, newly qualified nurses struggle to gain respect from older, experienced colleagues due to their age, which negatively affects communication and ultimately patient care (Phillips et al., 2013: 109; Thopola et al., 2013: 174-175). Furthermore, newly qualified nurses report that being called names, undermined (Khunou, 2019: 7), ignored and disrespected (Du Plessis, 2012: 36; Thrysoe et al., 2011: 554) are some of the barriers to effective communication.

Additionally, most newly qualified nurses experience hostility in the work environment, which negatively affects their confidence and make them feel vulnerable (Walker, Costa, Foster & De Bruin, 2016: 509). The lack of confidence and vulnerability caused

by an unsupportive and uncivil work environment has an adverse effect on patient care as the risk of clinical errors increase (Mammen, Hills & Lam, 2018: 594-595). Many newly qualified nurses are ill-prepared for the unprofessional workplace behaviour and consider the nursing culture as negative and intimidating (Walker et al., 2016: 509).

Also, many newly qualified nurses experience bullying in the workplace (Khunou, 2019: 8; Hofler & Thomas, 2016: 134; Vogelpohl, Rice, Edwards & Bork, 2013: 414-422; Laschinger, Wong & Grau, 2012: 1266-1276). Bullying is defined as the persistent mistreatment of another person and usually involves a power imbalance between the bully and the victim (Vogelpohl et al., 2013: 415-416). Most literature has identified nursing peers as the likely perpetrators of bullying. This is a concerning finding, as experienced nurses are expected to help newly qualified nurses integrate into the profession (Vogelpohl et al., 2013: 419-420).

2.4.4 Loss of control over executing professional practice values and roles

Newly qualified nurses find it difficult to practice according to the professional values, norms and standards learned during their nursing training, leaving many newly qualified nurses with feelings of frustration and guilt (Duchscher, 2009: 1107).

Newly qualified nurses face challenges with the poor quality of care provided to patients due to staff shortages (Flinkman & Salantera, 2014: 1053); high patient numbers compared to nurses (Abiodun et al., 2019: 8); and unsupportive workplace conditions and culture (Matlhaba et al., 2019: 5; Khunou, 2019: 7-9), with many feeling powerless to change these conditions (Flinkman & Salantera, 2014: 1053). The conflict between nursing school values and professional practice values was identified in Kramer's (1974: 1-249) Reality Shock Theory, which described the role transition experiences of nurses – from being a nursing student to being a practicing professional.

2.4.5 Exhaustion

Duchscher (2009: 1107) describes this as the excessive energy expended by newly qualified nurses while adjusting to the work environment. Newly qualified nurses experience exhaustion by the third to fourth month of transition as a result of trying to cope with adapting to the clinical environment (Duchscher, 2009: 1107). Furthermore, newly qualified nurses fear being exposed as incompetent, unsafe practitioners who

are unable to cope with their roles and responsibilities (Duchscher, 2009: 1107). Various studies confirm these findings as newly qualified nurses in these studies also experienced emotional, physical and intellectual exhaustion in the first few months of transitioning to practice (Hofler & Thomas, 2016: 133; McCalla-Graham & De Gagne, 2015: 125; Flinkman & Salantera, 2014: 1053; Laschinger et al., 2012: 1273).

Newly qualified nurses have to cope with increased workloads due to staff shortages (McCalla-Graham & De Gagne, 2015: 125; Flinkman & Salantera, 2014: 1053-1055); role conflict (Govender et al., 2017: 18-19); inadequate staffing skill mixes (Philips et al., 2013: 108) and bullying (Vogelpohl et al., 2013: 414-422; Laschinger, et al., 2012: 1266-1276), which all result in fatigue and burnout. Fatigue and burnout have been shown to negatively affect staff retention (Flinkman & Salantera, 2014: 1053; Laschinger et al., 2012: 1273). Therefore, adequate support from managers and staff are needed to facilitate the successful transitioning of newly qualified nurses into practice in order to retain these new nurses (Khunou, 2019: 11-12; Laschinger et al., 2012: 1273).

The retention of newly qualified nurses is vital in the current global health climate, which has seen a decline in the nursing workforce, leading to nursing shortages (Missen et al., 2014: 2420). The community service year is therefore important for newly qualified health professionals, including nurses, as nurses' transition into the workplace can be facilitated by adequate support to improve their knowledge, practical skills, critical thinking abilities and professional behaviours.

2.4.6 Impractical performance expectations

Newly qualified nurses are overwhelmed during the first months of transitioning to clinical practice as they are expected to function as experienced nurses and take on full responsibilities (Duchscher, 2009: 1106-1107). Impractical performance expectations by newly qualified nurses, co-workers and health establishments also influence the amount of stress experienced by newly qualified nurses (Duchscher, 2009: 1106). Health establishments and co-workers expect newly qualified healthcare professionals to be work ready when they assume their duties (Hofler & Thomas, 2016: 133; Khunou, 2019: 7). The issue of practice readiness and competency of newly qualified nurses have been discussed extensively in literature (Abiodun et al., 2019: 8; Matlhaba et al., 2019: 8; Hofler & Thomas, 2016: 133-136; Lima, Newall,

Jordan, Hamilton & Kinney, 2016: 878-888; Edwards et al., 2015: 1254-1268; Missen, McKenna & Beauchamp, 2015: 1-11; McCalla-Graham & De Gagne., 2014: 122-128; Burke, Sayer, Morris-Thompson & Marks-Maran, 2014: 1283-1289; Flinkman & Salantera, 2014: 1054-1055; Theisen & Sandau, 2013: 406-414; Philips et al., 2013: 106-111; Thrysoe et al., 2011: 551-555; Govender et al., 2017: 18-19; Roziers et al., 2014: 95-99; Govender et al., 2015: 5-7; Du Plessis, 2012: 29-30).

Newly qualified nurses' stress and anxiety levels are increased when dealing with situations for which they feel unprepared for (Flinkman & Salantera, 2014: 1053-1054). In addition, newly qualified nurses are often left to deal with circumstances that far exceed their current level of competence (Phillips et al., 2013: 108-110). Furthermore, most of these newly qualified nurses do not receive the appropriate support from senior colleagues when faced with new clinical challenges (Flinkman & Salantera, 2014: 1054).

In South Africa, although some community service nurses feel excited about and proud of their new title, many of them are overwhelmed by the huge responsibility of the new role (Govender et al., 2017: 18-19; Roziers et al., 2014: 95-97). Doctors and colleagues expect these nurses to know everything even though they are newly qualified (Khunou, 2019: 7; Govender et al., 2017: 18; Du Plessis, 2012: 29-30). Also, community service nurses are expected to be in charge of units, with many feeling unprepared for the responsibility (Matlhaba et al., 2019: 5; Abiodun et al., 2019: 8; Govender et al., 2017: 18-19; Roziers et al., 2014: 95-96).

2.5 PHYSICAL CHANGES

Newly qualified nurses experience extreme physical, emotional and intellectual exhaustion as they deal with transition shock, including personal and developmental changes (Duchscher, 2009: 1107-1108).

Adapting to their new professional role requires more responsibility and accountability that elicit further stress and anxiety as many of the newly qualified nurses feel inadequate in making advanced clinical decisions (Duchscher, 2009: 1108). These findings are consistent with other studies that show that most newly qualified nurses feel unprepared to accept the responsibilities and decision-making expected of them as it exceeds their level of competence (Walker et al., 2016: 508). Impractical

performance expectations result in feelings of self-doubt, decreased confidence and increased stress levels in newly qualified nurses (Walker et al., 2016: 508). However, when newly qualified nurses are treated as transitioning nurses, they are gradually introduced to responsibilities (Walker et al., 2016: 508).

Also, newly qualified nurses must adapt to the physical demands of shift work as well as coping with constant thoughts about work when not physically at work (Duchscher, 2009: 1108). Similarly, three studies in Walker et al.'s (2016: 508) systematic review, report that newly qualified nurses had difficulty adapting to shift work and that fatigue had a negative impact on the newly qualified nurses and their patients.

2.6 INTELLECTUAL CHANGES

In Duchscher's theory, this concept refers to newly qualified nurses' experiences during and after the orientation period in the clinical environment (Duchscher, 2009: 1109). During the orientation period, newly qualified nurses are excited and keen to assume their new independent role (Duchscher, 2009: 1109; Mammen et al., 2018: 594). Moreover, the new role felt familiar to them as they compared it to their clinical rotations as students (Duchscher, 2009: 1109). The new role expectations were seen as building on previously learned knowledge and skills, which were similar to advancing yearly as students (Duchscher, 2009: 1109). Likewise, community service nurses in Du Plessis (2012: 3) and Roziers et al. (2014: 95) affirm these results as they describe having positive attitudes and feeling passionate and confident when starting their new professional role.

Subsequently, during the orientation period, the newly qualified nurses had not experienced their full responsibilities or workload. Therefore, many of the nurses were stunned after the completion of orientation when faced with their full responsibilities and workload (Duchscher, 2009: 1109). Feelings of exhilaration and wonder swiftly turned into overwhelming doubt, fear and stress, since no one had discussed the concept of transitioning with them (Duchscher, 2009: 1109). Therefore, poor orientation is a barrier to the successful transitioning of newly qualified nurses, as it affects their ability to adapt to new environments (Phillips et al., 2013: 108-109; Flinkman & Salantera, 2014: 1054; Thopola et al., 2013: 173-174; Govender et al., 2015: 5; Khunou, 2019: 9-10).

Furthermore, the experience of transition shock is intensified as newly qualified nurses are allocated to patients and units above their competence level (Phillips et al., 2013: 108); given too much responsibilities too soon (Govender et al., 2017: 18-19); and left alone in units without adequate orientation (Ankers et al., 2017: 322; Thopola et al., 2013: 173-174), which leaves newly qualified nurses feeling uncertain, abandoned and fearful of making fatal errors (Flinkman & Salantera, 2014: 1054).

Furthermore, difficulty in adjusting to increased responsibilities are largely attributed to managers, senior nurses and clinical educators' approach to orientation (Duchscher, 2009: 1109). Many senior nursing staff and clinical educators fail to understand the level of competence of these newly qualified nurses and expect them to function as experienced nurses within a short period of time (Duchscher, 2009: 1109). For instance, nurse managers and senior nurses expect community service nurses to be competent and practice independently (Netshisaulu & Maputle, 2018: 4), but most newly qualified nurses are not ready for practice in their new roles since they lack confidence in their basic clinical skills (Matlhaba et al., 2019: 5; Burke et al., 2014: 1286).

However, nurse managers acknowledge that community service nurses require orientation and supervision during the initial months of transitioning from student to registered nurse (Govender, Brysiewicz & Bhengu, 2016: 66-67), but some nurse managers feel that it requires a lot of work to get newly qualified nurses to an acceptable and safe practice standard (Burke et al., 2014: 1286). Community service nurses require orientation, support from management and clinical supervision to be able to function effectively within the clinical environment (Khunou, 2019: 10; Reid et al., 2018: 747).

Moreover, newly qualified nurses are supervised by an experienced nurse based on a division of workload as opposed to a preceptor-preceptee relationship (Duchscher, 2009: 1109). However, some challenges have been identified regarding the assignment of preceptors to newly qualified nurses such as the unavailability of preceptors due to incorrect rostering, no assignment of preceptors and unapproachable preceptors (Walker et al. 2016: 510).

Further to this, newly qualified nurses do not easily approach senior nurses as everyone carries a heavy workload (Duchscher, 2009: 1109). Whereas some

community service nurses do not dread asking questions of senior staff (Roziers et al., 2014: 95; Govender et al., 2017: 18), other newly qualified nurses experienced difficulty and learned to identify staff who were approachable and helpful (McCalla-Graham & De Gagne, 2015: 125; Ankers et al., 2017: 322). At the same time, nurse managers and senior nurses are frustrated by the amount of supervision required by new community service nurses (Govender et al., 2016: 65; Netshisaulu & Maputle, 2018: 4-5).

In addition, newly qualified nurses fear being regarded as incompetent if they continuously request assistance from their colleagues (Duchscher, 2009: 1106-1109). Similarly, in other studies, experienced nurses often make newly qualified nurses feel inept and slow (Mammen et al., 2018: 594), which affects their participation in ward activities. Many newly qualified nurses do not participate in ward discussions, doctors' rounds and handover rounds, as they are unsure of how their colleagues perceive their competence (Thrysoe et al., 2011: 554).

Newly qualified nurses should not be used to relieve staff in other areas as it intensifies the transition shock experience when being allocated to different units (Duchscher, 2009: 1109). Inadequate staffing is usually one of the main reasons why staff are re-allocated to other areas (Thopola et al., 2013: 175-176; McCalla-Graham & De Gagne, 2015: 125). Additionally, the normal three- to four-monthly ward rotations are already distressing for newly qualified nurses as they must adapt to new environments, patients, policies and procedures (Walker et al., 2016: 508; Ankers et al., 2017: 322; Mammen et al., 2018: 596); therefore, being used as relief staff causes the same level of anxiety and apprehension.

Newly qualified nurses already have doubts about their performance due to their lack of practical experience and are challenged beyond their capabilities (Duchscher, 2009: 1109). Unrealistic performance expectations (as noted earlier in 2.4.6) from newly qualified nurses leads to insecurity, decreased confidence and high anxiety and stress levels (Walker et al., 2016: 508; Khunou, 2019: 9-10).

2.7 SOCIO-DEVELOPMENTAL CHANGES

The first few months of role transitioning is characterized by social-developmental changes for newly qualified nurses. During this period, newly qualified nurses establish

a professional identity, separate that identity from others around them, gain acceptance from colleagues, balance personal and work life and integrate theory with practice (Duchscher, 2009: 1108). The experience of transition shock is mainly dependent on collegial relationships (Duchscher, 2009: 1108).

Newly qualified nurses develop into more mature, professional people and establish their professional identities (Duchscher, 2009: 1108). Likewise, in studies concerning community service nurses, independent practice upon commencing their community service year produces feelings of excitement, joy and satisfaction (Du Plessis, 2012: 3; Roziers et al., 2014: 95). At the same time, professional growth and maturity in the new role is met with enthusiasm (Roziers et al., 2014: 95) and confidence about becoming good nurses (Mammen et al., 2018: 594), with a real passion to make a difference (Du Plessis, 2012: 3).

Furthermore, many community service nurses realise that they have entered the professional world and must behave accordingly by being responsible and accountable (Govender et al., 2017: 17-18). They are confident in providing and contributing positively towards satisfactory patient care (Walker et al., 2016: 510; Thrysoe et al., 2011: 553). Community service nurses' ability to successfully manage wards lead to professional development and increased self-worth (Roziers et al., 2014: 95; Walker et al., 2016: 510; Khunou, 2019: 9).

Most community service nurses can identify their strengths and weaknesses and are able to deal with challenges in the workplace (Govender et al., 2017: 17; Roziers et al., 2014: 95). Moreover, newly qualified nurses' confidence in clinical practice improves with time as ward routines become familiar and tasks are completed timeously (Ankers et al., 2017: 322).

By comparison, some community service nurses feel underutilised as they are treated as students (Du Plessis, 2012: 4; Govender et al., 2017: 19), while others feel fearful of the new role and responsibilities (as they are expected to manage wards) (Roziers et al., 2014: 95). Some healthcare professionals underestimate their performance abilities (Govender et al., 2017: 18; Phillips et al., 2013: 109). Also, some community service nurses are not acknowledged as professional nurses by colleagues (Govender et al., 2015: 6), which undermine newly qualified nurses' practice and confidence (Phillips et al., 2013: 109).

In addition, some newly qualified nurses realise their vulnerability due to inadequate practical knowledge, skills and experience (Mammen et al., 2018: 594). However, these newly qualified nurses utilise internal personal strengths and support systems to overcome challenges and attain self-actualization (Mammen et al., 2018: 595). In striving for self-actualization, newly qualified nurses learn independently and become self-reliant (Mammen et al., 2018: 595).

Newly qualified nurses want to be accepted by their colleagues and be part of the nursing team (Duchscher, 2009: 1108). Newly qualified nurses feel valued when they are consulted (Du Plessis, 2012: 4) as they can contribute with their knowledge and skills (Thrysoe et al., 2011: 553). Also, community service nurses find it rewarding when they are able to work as colleagues (Du Plessis, 2012: 3) and appreciate the peer support (Govender et al., 2015: 5-6). Provision of constructive feedback from nurse managers about newly qualified nurses' clinical performance increases confidence and competence, which is vital for successful transition (Phillips et al., 2013: 109; Roziers et al., 2014: 95). Similarly, community service nurses' eagerness to perform professional duties are appreciated by nurse managers, as it shows that they want to learn more (Govender et al., 2016: 64). Positive support from nurse managers and clinical support staff contributes towards improved performance (McCalla-Graham & De Gagne, 2014: 125).

However, some community service nurses experience specific challenges in the practice environment. Nursing managers seem unprepared and uncertain about how to deal with them, which leave them feeling bewildered in the clinical area (Du Plessis, 2012: 4-5). Also, newly qualified nurses are unprepared for the negative nursing culture they experience (Walker et al., 2016: 509). In addition, some staff are disrespectful by purposefully ignoring community service nurses' professional role (Roziers et al., 2014: 95) and making assumptions that they had minimal experience before their existing role (Phillips et al., 2013: 109). Some older nurses also do not show respect to young newly qualified nurses (Phillips et al., 2013: 109).

Several newly qualified nurses feel that they are set up for failure as respect is determined by the nursing culture and environment and support from nurse managers and colleagues are not always forthcoming (Phillips et al., 2013: 109; Flinkman & Salantera, 2014: 1054). Studies have shown that newly qualified nurses' job

satisfaction and retention are directly influenced by the behaviour and attitudes of the nurse managers closest to them (Flinkman & Salantera, 2014: 1054). Newly qualified nurses need support and guidance to feel safe and competent but are faced with constant scrutiny and judgement, which affect their confidence and patient care (Mammen et al., 2018: 594).

Some community service nurses find it difficult to maintain a balance between their personal and professional lives. The impact of workplace challenges usually affects newly qualified nurses' personal lives. For instance, newly qualified nurses experience exhaustion due to unreasonable workloads (McCalla-Graham & De Gagne, 2014: 125; Flinkman & Salantera, 2014: 1053) and struggle to adapt to shift work (Walker et al., 2016: 508) and workplace incivility (Mammen et al., 2018: 594: Ankers et al., 2017: 322). Several newly qualified nurses lack motivation to go to work because of these challenges (McCalla-Graham & De Gagne, 2014: 125; Ankers et al., 2017: 322).

In addition, exhaustion, shift work and workplace incivility have a negative impact on newly qualified nurses' health and family life as many experience burnout, fatigue, anxiety and depression (Mammen et al., 2018: 594; Flinkman & Salantera, 2014: 1053; Walker et al., 2016: 508). Also, many community service nurses have issues with inadequate salaries as they are responsible for study loan payments and have to provide for their families and themselves (Thopola et al., 2013: 175; Govender et al., 2017: 19). However, some newly qualified nurses are eager to go to work because of the friendships made with colleagues (Ankers et al., 2017: 322). Newly qualified nurses experience a sense of belonging with co-workers when mutual interest in private lives are shown (Thrysoe et al., 2011: 555).

The community service year provides an opportunity for newly qualified nurses to integrate nursing education with clinical practice, since they gain valuable experience (Khunou, 2019: 9; Govender et al., 2017: 17). The integration of theory and practice is facilitated by adequate supervision, which enhances newly qualified nurses' competence (Netshisaulu & Maputle, 2018: 4). Many newly qualified nurses can develop professionally by improving their knowledge and skills through clinical rotation and exposure to added responsibilities like unit management and student supervision (Govender et al., 2017: 17; Govender et al., 2015: 6; Abiodun et al., 2019: 7).

However, some newly qualified nurses experience a disconnect between theory and clinical practice (Abiodun et al., 2019: 8; Ankers et al., 2017: 322). Several newly qualified nurses feel unprepared for clinical practice as educational institutions concentrate too much on theory (Flinkman & Salantera, 2014: 1054; McCalla-Graham & De Gagne, 2014: 124). In order for community service nurses to function effectively in the practical environment, clinical competence is needed (Netshisaulu & Maputle, 2018: 4; Theisen & Sandau, 2013: 409). Newly qualified nurses must be able to think critically and make informed clinical decisions (Theisen & Sandau, 2013: 409). Also, other practical skills such as leadership, conflict management, time management and prioritization are required for effective and efficient clinical practice (Theisen & Sandau, 2013: 409; Walker et al., 2016: 508).

Furthermore, positive professional relationships enable community service nurses to participate confidently in ward activities and patient care (Du Plessis, 2012: 3; Ankers et al., 2017: 322; Matlhaba et al., 2019: 4), thus reducing the transition shock experience (Duchscher, 2009: 1108).

2.8. SUMMARY

An extensive literature review was done in order to discuss newly qualified nurses' experiences of their compulsory community service year. Duchscher's transition shock theory was applied, as the secondary purpose of community service is to support newly qualified professionals' transition period. The literature review provided contrasting views of newly qualified nurses' experiences of their transition from students to working professionals. In addition, the review highlighted facilitators of and barriers to effective transition to professional practice. The next chapter will discuss the methodology of the study, supported by relevant literature.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 1 provided an outline of the study and Chapter 2 described the literature review. Chapter 3 provides a discussion of the methodology used in this study. A thorough description of the research methodology of a study ensures credibility of the process and findings (Bengtsson, 2016: 10). This chapter commences with restating the aims and objectives of this study, after which a detailed description of the study setting is provided. A comprehensive description of the research design and rationale for selecting an exploratory-descriptive qualitative design is then presented. The subsequent sections discuss the selection of the population, sampling methods, data collection tool, pilot interview and trustworthiness of the study. The chapter concludes with a discussion of how data was collected, analyzed and interpreted.

3.2 AIM AND OBJECTIVES

Brink et al. (2018: 74) offer that the research aim is a clear, concise description of the intention of the study and what the researcher hopes to achieve, with the research objectives being the steps taken to achieve the aim of the study. Both the aim and objectives must be tangible and measurable (Brink et al., 2018: 74).

The aim of this study was to explore and describe newly qualified nurses' experiences of their compulsory community service year at a Cape Town urban district hospital. The objectives of this study were to:

- explore newly qualified nurses' experiences of community service
- describe these experiences in relation to knowledge, practical skills, critical thinking abilities and professional behaviour development
- identify facilitators and barriers that influence a newly qualified nurse's ability to develop knowledge, practical skills, critical thinking and professional behaviours during the community service year

3.3 STUDY SETTING

The study was conducted in Cape Town within the Southern Peninsula Health District of the Metro Region at an urban district hospital. The urban district hospital, located in the southern suburbs of Cape Town, provides health services to the poorer communities who suffer a heavy burden of disease (Western Cape Department of Health, 2005: 3-6).

The urban district facility is a teaching hospital that offers care in the disciplines of medicine, surgery, emergency services, paediatrics, orthopaedics, radiology, psychiatry, physiotherapy, social services, dietetics, forensics, psychiatry and pharmacy (Western Cape Government, 2019). The hospital also hosts outpatient care facilities and operating theatres for both major and minor operations. Furthermore, the urban district hospital offers 180 beds and sees an average of 330 outpatients a day and 3000 emergency patients a month (Western Cape Government, 2019). The percentage bed occupancy for the past year is 94% and the average length of stay is 3.9 days for the same period (Western Cape Government, 2019). This hospital serves four corners of Cape Town: from Wynberg in the north; Hout Bay in the west; Phillipi and Mitchell's Plain in the east; and Masiphumelele and Simon's Town in the south (Western Cape Government, 2019).

3.4 RESEARCH DESIGN

The research design is the plan for conducting a study and guides the selection of a population and sampling procedure, the collection and analyses of data, and the interpretation of the results (Brink et al., 2018: 104). The research design follows logical steps in order to answer the research question (Brink et al., 2018: 103). This study applied a qualitative approach with an exploratory-descriptive research design (Gray et al., 2017: 133).

3.4.1 Qualitative approach

Qualitative research is a process of naturalistic, inductive and deductive inquiry that seeks in-depth understanding of social phenomena within their natural setting (Brink et al., 2018: 104; Creswell, 2014: 234). It is an intellectual approach used to explore the richness and complexity intrinsic to people's lives (Gray et al., 2017: 122). In this

study, a qualitative research approach allowed the researcher to explore and describe newly qualified nurses' experiences about compulsory community service within their natural setting (Gray et al., 2017: 122). Qualitative research methodology answers questions about experience, meaning and perspective from a person's viewpoint, which would be difficult to count or measure (Brink et al., 2018: 103-104). Therefore, words rather than numbers are used in qualitative research to study human's experiences (Brink et al., 2018: 104; Lobiondo-Wood & Haber, 2014: 96). Thus, a qualitative approach provided the researcher with an opportunity to gather narrative data from newly qualified nurses about their experiences of compulsory community service.

3.4.2 Exploratory-descriptive design

An exploratory, descriptive research design is used to address an identified knowledge-gap, which can only be answered through seeking the perspectives of the people most affected (Gray et al., 2017: 133). This type of research design is usually applied when researchers are exploring a new topic or describing a situation (Grove et al., 2015: 77). According to Grove et al. (2015: 77), exploratory-descriptive qualitative studies are developed to provide information and insight for clinical or practice problems. In this study, this design supported the researcher in coming to an understanding of the needs, preferred outcomes and opinions of newly qualified nurses in the context of their experience of compulsory community service (Gray et al., 2017: 71).

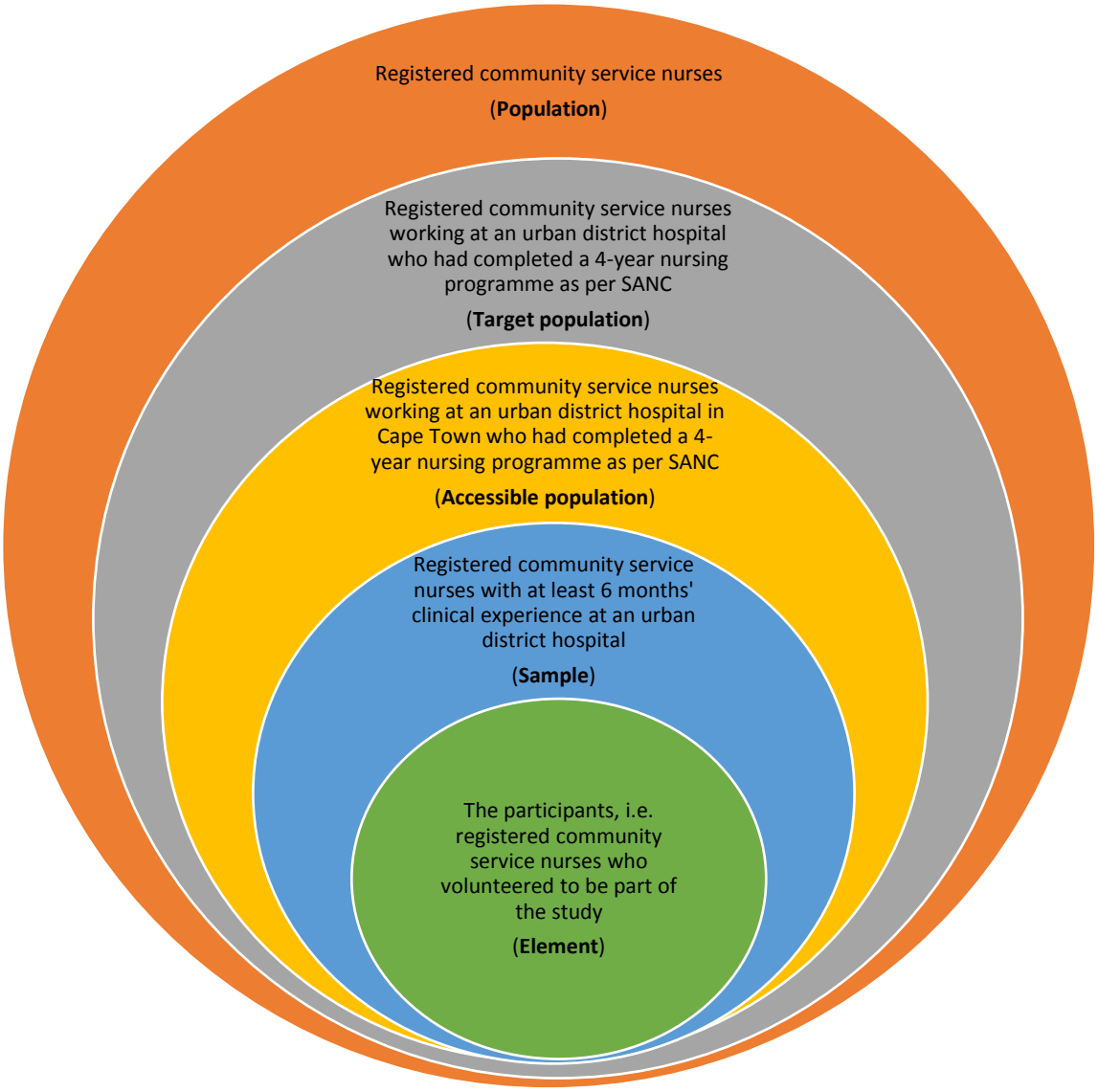
3.5 POPULATION AND SAMPLING

The population is a specific group of people or elements that are the focus of the research (Gray et al., 2017: 516) and meet the criteria of interest to the researcher (Brink et al., 2018: 116). The target population is the entire set of persons or elements that meet the sampling criteria (Gray et al., 2017: 516). For this study, the target population included registered community service nurses who work at an urban district hospital and who had completed a 4-year nursing programme as per the SANC (Republic of South Africa, 2007: 46-49). However, the researcher may only have access to a part of the population, which is referred to as the accessible or study population (Brink et al., 2018: 116; Gray et al., 2017: 516). In this work, the study

population included all registered community service nurses working at an urban district hospital in Cape Town who had completed a 4-year nursing programme as per the SANC (Republic of South Africa, 2007: 46-49). Purposive sampling is a type of non-probability sampling method, which provided the researcher with an opportunity to select participants from the accessible population who are the most knowledgeable about the study phenomenon (Brink et al., 2018: 126).

Urban district hospitals employ registered community service nurses in various stages of their community service year. Therefore, I refined the sample further by only including community service nurses with at least six months' clinical experience at an urban district hospital so that rich and comprehensive data about newly qualified nurses' experiences of their community service year could be collected. The community service nurses who voluntary participated in the study were the research participants. I adapted the figure used by Gray et al. (2017: 517) to show the relationships between the population, target population, accessible population, sample and participants (element) as they apply to this study (Figure 3.1).

Figure 3.1: Linking the population, sample and participants of the study



3.5.1 Sampling strategy

Sampling is the process of selecting study elements or participants from a population (Gray et al., 2017: 515). The sample must represent the study population, meaning that the sample population should be as similar to the whole population as possible (Brink et al., 2018: 115-117). Furthermore, the sampling or eligibility criteria determines the target population, and the sample is chosen from the accessible population within the target population (Gray et al., 2017: 518).

Sampling criteria comprise of a list of characteristics that a target population must possess in order to be eligible for a study (Brink et al., 2018: 116). However, sampling

criteria are made up of both inclusion and exclusion criteria. Inclusion sampling criteria are characteristics that an element or participant must have in order to be included in the target population (Gray et al., 2017: 18), whereas exclusion sampling criteria are characteristics that would cause an element or participant to be excluded from the target population (Brink et al., 2018: 116). This study only used inclusion sampling criteria, as outlined below.

3.5.1.1 Inclusion criteria

- Newly qualified registered community service nurses with at least six months' clinical experience as a community service nurse in an urban district public health facility.
- Registered nurses who completed the community service year no more than four months prior to the data collection period at a public health facility.

In this study, a purposive sampling method was applied in order to obtain rich, contextual data about newly qualified nurses' experiences of their compulsory community service year. Purposive sampling is a type of non-probability sampling method where the researcher selects participants who are the most knowledgeable about the study phenomenon (Brink et al., 2018: 126). Purposive sampling was the method of choice, as the study required participants who could best answer the research question. In this study, registered community service nurses were the study population, since they were able to provide rich and comprehensive data about newly qualified nurses' experiences during the community service year.

3.5.2 Sample size

In this study, purposive sampling was used, as it allowed the researcher to sample until data saturation was deemed to have been achieved (Brink et al., 2018: 126). Data saturation was deemed to have been reached when no new data emerged during the semi-structured interviews and all themes were refined. This then determined this study's sample size (LoBiondo-Wood & Haber, 2014: 101; Fusch & Ness, 2015: 1408-1410; Brink et al., 2018: 126). The final study sample comprised of five participants out of the 13 community service nurses. The sample size was considered adequate as the data was fully explored and the meanings were clear (Brink et al., 2018: 128).

Data was analyzed by qualitative content analysis. Bengtsson (2016: 10) argues that there are no established criteria for sample size in qualitative content analysis.

3.6 DATA COLLECTION TOOL

The semi-structured interview guide (see Appendix 7) was developed from the literature review. The research question and purpose provided a focus for the questions with which in-depth, rich data of newly qualified nurses' experiences of their compulsory community service year was obtained. The semi-structured interview guide was informed by Creswell's (2014: 244) interview guidelines, which detail some of the components required for an interview protocol.

A semi-structured interview guide comprises of a list of pre-constructed open-ended questions and probes that focus the interview on specific aspects of the study phenomenon (Turner III, 2010: 755; Gray et al., 2017: 414). The semi-structured interview guide approach is more structured than the conversational, informal approach of unstructured interviews, yet less rigid than structured interviews (Turner III, 2010: 754).

The semi-structured interview guide (see Appendix 7) used in this study consisted of four open-ended questions and a list of prompting questions to allow the participants' viewpoint to emerge (Gray et al., 2017: 414). This type of approach allows the researcher to remain open to participants' responses and ask probing questions (Gray et al., 2017: 414). In addition, the semi-structured interview guide had an allocated area for recording field notes (Creswell, 2014: 244). Additional data was recorded on a notepad when the space became limited. The following is an example of the questions and probing words used during the interview:

> Could you please tell me about your experiences of and during your community service year?
>
> Probes:
>
> 1. What are some of your reasons for liking/ disliking it?
> 2. Can you explain further ….?
> 3. Can you give me an example of ….?

The semi-structured interview guide was reviewed by the study supervisor and Stellenbosch University's Health Ethics Research Committee (see Appendix 1) to ascertain whether it would accurately measure newly qualified nurses' experiences of the community service year (Gray et al., 2017: 586). A pilot interview was conducted to establish the feasibility of the interview and to determine if semi-structured questions in the interview guide would elicit sufficient and rich data with a participant (Gray et al., 2017: 628).

3.7 PILOT INTERVIEW

A pilot interview was conducted before the main study to determine if there are any flaws with the semi-structured interview guide and to assess the feasibility of the study (Brink et al., 2018: 45-46). Moreover, the pilot interview allowed for the testing of the researcher's interview skills, the audio-recording equipment and the location of the interviews to ensure the smooth flow of the interview process (Brink et al., 2018: 46). A community service nurse from the urban district hospital who met the inclusion criteria of the study was approached to participate in the pilot interview (Brink et al., 2018: 161).

The researcher had undergone interview skills training and had been evaluated during a training session offered by Stellenbosch University before the study commenced (Gray et al., 2017: 415-416). After obtaining ethical approval and institutional permission, which is elaborated on in the data collection section (see section 3.9) of this thesis, I initiated contact with the community service nurse who gave informed consent and participated in the pilot interview. The location was selected according to the participant's needs and comfort; hence, the interview took place at the participant's home (Gray et al., 2017: 413-414). The researcher conducted and audio-recorded the interview, which was then safely stored and transcribed (see Section 3.9 for more details). The interview data was included in the study after determining that no changes were required to the semi-structured interview guide or interview process.

3.8 TRUSTWORTHINESS

Trustworthiness in qualitative studies is ensured by using four criteria to determine rigour (Polit & Beck, 2018: 295-296; Grove et al., 2015: 68). Scientific rigour is important since it is linked to the value or worth of the research findings (Gray et al.,

2017: 124). The four criteria applied in this study are credibility, transferability, dependability and confirmability.

3.8.1 Credibility

Credibility refers to internal validity whereby the researcher attempts to provide an accurate depiction of the phenomenon under study (Polit & Beck, 2018: 295-296; Shenton, 2004: 63-68).

In this study, four methods were used to ensure credibility. Firstly, during data collection, the researcher wanted to support the study participants in their offering of rich, truthful data about their experiences. This was achieved through various methods. First of all, participants provided informed consent to participate in the study. On commencement of the semi-structured interviews, the participants were reminded that they could withdraw from the study at any time. This ensured that they were willing participants, prepared to offer information freely. The participants were informed that they could answer the questions in any manner as there was no right answers. Furthermore, I re-affirmed my independent status to the participants due to my past relationship with the facility, as I wanted them to be open and honest about their experiences. Additionally, I had regular meetings with my supervisor who offered varied perspectives about the development of the study. These debriefing sessions allowed me to voice my developing thoughts and interpretations of the study (Polit & Beck, 2018: 295-296; Shenton, 2004: 67).

Secondly, the audio-recorded semi-structured interviews were transcribed verbatim to provide accurate data. The researcher checked the interview transcripts for errors by listening to the recordings while reviewing the transcripts (Gray et al., 2017: 414). Thirdly, during the data analysis process, data from the interview transcriptions and field notes was triangulated to create a justification for the emerging themes (Polit & Beck, 2018: 299). Fourthly, the data, coding and themes were reviewed by a peer to check whether she made the same interpretations.

3.8.2 Transferability

Transferability refers to external validity or generalizability. It involves the extent to which the study findings can be applied or generalized to other settings (Polit & Beck,

2018: 296; Shenton, 2004: 69-71). In this study, rich, thick and contextual descriptions of newly qualified nurses' experiences of their compulsory community service year were communicated so that other researchers can transfer the findings to additional settings.

3.8.3 Dependability

Dependability refers to reliability, which is established when similar results are obtained when the study is replicated in a comparable context using the same methods and participants (Shenton, 2004: 71-72). In this study, I provided detailed accounts of the procedures and processes that were followed. This enabled the study to be audited by a peer to determine whether it was acceptable and therefore dependable (Brink et al., 2018: 111).

3.8.4 Confirmability

Confirmability, which signifies objectivity, was accomplished by demonstrating that the findings of the study emerged from the data and not from the researcher's personal bias (Shenton, 2004: 72). In this study, I clarified any bias by disclosing my personal, past relationship with the institution and by keeping a reflective journal from the start of the study to record ongoing thoughts about my previous experience regarding the study phenomenon (Polit & Beck, 2018: 296).

3.9 DATA COLLECTION

Data collection is the process undertaken to answer the research question. It involves the creation of an audit trail detailing how data was collected and analyzed and what the rationale for the selected method was (Cypress, 2018: 303; Brink et al., 2018: 133). Figure 3.2 below depicts a flow diagram of the data collection process of this study.

Figure 3.2 Data collection process applied in this study

Firstly, approval and permissions are required to gain entry to study settings (Cypress, 2018: 303). Ethical approval to conduct the study was obtained from Stellenbosch University's HREC (S17/02/031; see Appendices 1 & 2). In addition, permission to conduct the study at the urban district hospital was acquired from the Western Cape Health Department (WC_2017RP35_863; see Appendix 3) and the head of medicine (see Appendix 4).

The researcher conformed to the study's qualitative method of inquiry by involving a gatekeeper to gain access to potential research participants (Creswell, 2014: 237). The head of medicine at the urban district hospital acted as the gatekeeper as he was the person who allowed the study to be conducted at the facility and provided access to the potential participants (Creswell, 2014: 237). Subsequently, copies of the

research proposal synopsis and approval letters were sent via email to the head of medicine (see Appendix 4). The head of medicine appointed the head of nursing to act as mediator to assist the researcher in recruiting study participants.

I arranged and met with the head of nursing to explain the purpose and nature of the study. The head of nursing included the two area managers in this meeting in the event that he would be unavailable for follow-up consultations. Consequently, the area managers provided a list of possible participants (employed at that time) who met the inclusion criteria. This ensured a fair inclusion and treatment of participants (Brink et al., 2018: 30). In addition, the area managers supplied ward allocation lists and duty rosters of the potential participants. Further to this, the area managers introduced the researcher to the institution's clinical educator as the Clinical Education Department was identified as the most suitable location for recruiting potential participants. The Clinical Education Department was deemed appropriate, as it is separate from the hospital and the management suite, which provided a means of confidentiality and anonymity to the prospective participants (Brink et al., 2018: 28).

The mediators arranged for the potential participants to meet with me in a designated training room in the Education Department. At the beginning of the information sessions, after introducing myself and clarifying the purpose of the meeting, I disclosed to the prospective participants my past connection with the study setting (I was a student nurse at the urban district hospital between the years of 1996 to 1999). Furthermore, I was permanently employed by the institution from the years 2000 to 2005 and later as a temporary employee via a nursing agency from 2005 to 2009. This information was shared with the prospective participants to ensure their right to autonomy so that they did not feel coerced into the study by the mediators or myself (Brink et al., 2018: 29). The participants were informed that, although I have a past connection with the facility, I would not disclose any information about their participation or data to any of the staff (Brink et al., 2018: 28-29). This would protect them from any possible harassment and victimization (Brink et al., 2018: 29). A total of two information sessions were held in order to accommodate community service nurses on both day shifts.

During the information sessions, an adapted version of Stellenbosch University's HREC participant information leaflet and informed consent form (see Appendix 5) was distributed and explained in detail. These documents provided detailed information

about the research and the study participants' possible involvement (Brink et al., 2018: 31-32). The information leaflets and informed consent forms were available in English, Afrikaans and isiXhosa. The Afrikaans and isiXhosa versions of the information leaflets and informed consent forms were translated by Stellenbosch University's language centre (see Appendix 6). These translated copies were then given to registered professional nurses, who did not form part of the study, to read and provide feedback about the language and clarity. After receiving constructive feedback about the forms, copies were made available to the potential participants during the information sessions.

The study participants were given the opportunity to discuss any queries that they had about the study and informed consent forms (Brink et al., 2018: 29). The participants were also reassured that their participation is entirely voluntary and that they could withdraw from the study at any time or refuse to offer information (Brink et al., 2018: 29). This study required participants to share very personal experiences, which were anticipated to be of a sensitive nature at times. Consequently, they were informed that the Employee Assistance Programme (EAP) is available to them should a referral be required. The EAP has trained professionals, such as psychologists, who assist employees in dealing with personal issues.

The participants were advised to contact the researcher should further clarification about the study or their participation be required. The researcher's contact details were made available on the informed consent forms. After allowing the participants sufficient time to consider whether they would like to participate or not, the completed informed consent forms were collected at the end of each information session. A total of six out of the 13 consent forms were signed. All participants provided verbal consent for their interviews to be voice recorded.

Subsequently, I contacted the study participants telephonically to arrange a convenient date, time and place for the semi-structured interviews. Four of the participants confirmed that they would feel more comfortable to conduct the interviews at the Educational Department of the hospital, as it was familiar to them (Brink et al., 2018: 29). The participant who partook in the pilot interview felt more comfortable in the home environment during "off duty" time. However, the rest of the study participants preferred the interviews to take place on their duty days during their lunch

break. The researcher arranged to have refreshments available during this time. The sixth participant (assigned code number 3) decided to withdraw from the study, and his decision was respected without question (Brink et al., 2018: 29). I thanked him for attending the recruitment session and wished him well in his future endeavours.

The use of a training room in the Educational Department was arranged with the clinical educator prior to scheduling the semi-structured interviews. Furthermore, the clinical educator ensured that no training sessions were scheduled on the dates of the interviews to provide the participants with privacy (Brink et al., 2018: 28).

In qualitative research, data is usually collected by means of observation, interviews and focus groups (Gray et al., 2017: 409). I selected interviews as the data collection method for this study, as they are mostly used in exploratory-descriptive qualitative research when narrative data is collected (Brink et al., 2018: 143). More importantly, they allow the researcher to gather in-depth data as discussions with participants can be deepened (Bengtsson, 2016: 10). Moreover, an interview is a focussed conversation between the researcher and participant that produces textual data (Gray et al., 2017: 413). It also allows the researcher to gather non-verbal information such as facial expressions and nuances.

Consequently, I decided to conduct face-to-face, one-on-one semi-structured interviews with the study participants to elicit their views and opinions about newly qualified nurses' experiences during the compulsory community service year (Cypress, 2018: 303-304; Creswell, 2014: 239-240). By conducting semi-structured interviews, I was able to interact with participants in a calm, comfortable and informal manner. More importantly, I had the opportunity to learn about the in-depth experiences of the community service nurses during their compulsory community service year.

Care was taken to establish a positive environment in which to conduct the semi-structured interviews. Four of the participants preferred the hospital's educational training room as the location for the interviews and were therefore "on duty" and dressed in uniform. I was dressed in a semi-formal, neutral-coloured attire to reduce any perceived power differences in our relationship, as the participants were aware of my professional status (Gray et al., 2017: 416). The training room was prepared by moving the chairs around so that the participant and researcher were facing each other

across the table. I enquired whether the participants preferred the windows to be open or closed and the heater to be on or off (depending on the weather of the particular day). Refreshments were provided as some interviews took place during lunchtime or after the participants have worked half-days.

Four of the five interviews were conducted in English, as this was the choice of the participants and it tends to be the language of instruction for the four-year nursing programme at universities and colleges in South Africa. However, one of the participants felt more comfortable with Afrikaans. At the beginning of each semi-structured interview, I reminded the participants that the interview was being recorded. All interviews were audio-recorded by means of a voice recorder, which was positioned between the researcher and the participant. The researcher ensured that a back-up voice recorder and charger were available (Creswell, 2014: 244).

Interviews, like other types of data collection methods, have both strengths and weaknesses. The advantages of interviews as a data collection method are: i) they allow participants to offer information about the past, present and future; ii) they are useful when direct observation of participants is not possible; iii) they allow the researcher control over the line of questioning (Creswell, 2014: 241); and iv) they are more likely to provide rich and comprehensive data as opposed to other data collection techniques (Cypress, 2018: 304).

The disadvantages of interviews are: i) they provide indirect information from the participant's perspective; ii) they occur in a selected place as opposed to a natural field setting; iii) the researcher's presence may influence the participants' responses; and iv) not all persons are equally articulate or perceptive (Creswell, 2014: 241).

Although notes were made during the interviews, the researcher attempted to be as unobtrusive as possible in order to remain open and attentive towards the participant (Grove et al., 2015: 83). The field notes taken during the semi-structured interviews detailed demographic data about the date, time, place of the setting (Creswell, 2014: 244). Comprehensive field notes were recorded on a notepad after each interview (see Appendix 8). Additionally, I recorded information about the participants' non-verbal cues such as body language, emotional expressions, tone of voice and attitude (Gray et al., 2017: 418). Furthermore, reflective notes were made immediately after the interviews as well. I took time to reflect on individual interviews by recording my

thoughts, feelings, impressions, ideas, biases, issues and intuitions (Creswell, 2014: 244).

3.9.1 Data management

On completion of the interviews, I listened to the audio-recorded interviews for audibility and completeness. Each recording was labelled individually with the code number of each participant to ensure anonymity and confidentiality. The audio-recordings of the interviews were stored in a locked computer and backed-up on an external hard drive, which was kept in a locked box. Furthermore, all field notes were typed and stored in the locked computer, with back-ups made and the original documents filed and kept in a waterproof storage box.

The audio-recorded interviews were transcribed by an independent data transcriptionist (see Appendix 9). The transcript of the interview that was conducted in Afrikaans was translated to English by the researcher (see Appendix 10).

During the data analysis process, which is further elaborated on in Section 3.10, I transferred the electronic transcripts into a Microsoft Excel file to assist with data analysis. Individual copies of all Excel sheets (see Appendix 11) and transcripts were printed to enable the researcher to use coloured markers during the coding process.

3.10 DATA ANALYSIS

Data analysis is the process of categorizing, ordering, manipulating and summarizing data and assigning meaning to it (Brink et al., 2018: 165). Qualitative research produces narrative data, thus text as opposed to numbers (in quantitative studies) is analyzed (Brink et al., 2018: 180). In qualitative research, there are several approaches to analyzing the vast amount of information gathered during the data collection process. Qualitative content analysis is used to interpret and draw valid conclusions from the data collected (Bengtsson, 2016: 10). In this study, I used the qualitative content analysis methodology as described in Erlingsson & Brysiewicz (2017: 93-99).

Qualitative content analysis methodically transforms substantial text into a highly organized and succinct summary of significant results (Erlingsson & Brysiewicz, 2017: 94). I adapted the figure used in Erlingsson & Brysiewicz (2017: 94) to show how the

data analysis in qualitative content analysis led to higher levels of abstraction in my data.

Overarching theme: A complex experience

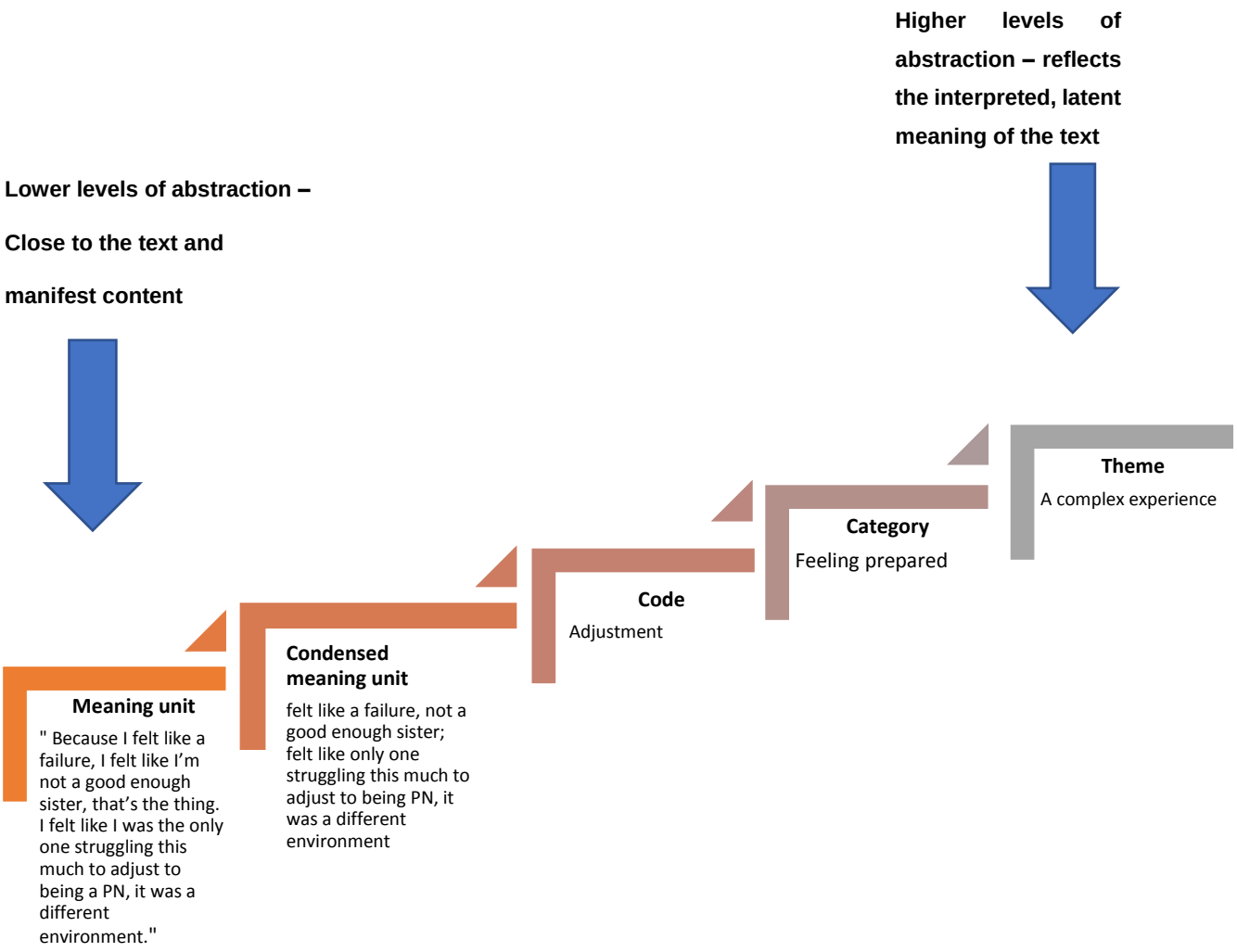


Figure 3.3 Data analysis leading to higher levels of abstraction: from manifest to latent content

The raw data from transcribed interviews (verbatim) was analyzed and categories and themes were identified. The development of categories and themes is a process of further abstraction of data – from manifest content to latent content or meaning (Erlingsson & Brysiewicz, 2017: 94). Throughout the data analysis process, I remained aware of my past experiences and personal and professional backgrounds by means of constant reflection and keeping a reflective journal. This ensured that the data could be analyzed abstractly (Creswell, 2014: 235). This ability to maintain awareness of past experiences and biases is referred to as reflexivity (Gray et al., 2017: 409). To have preconceived knowledge of and be acquainted with the phenomenon can be

advantageous provided that it does not influence the participants or interpretation of the findings (Bengtsson, 2016: 8).

The analysis of data in this study comprised of the following steps: i) immersion in the data; ii) dividing the text into meaning units; iii) condensing meaning units; iv) formulating codes; v) grouping codes into categories; and vi) creating themes (Erlingsson & Brysiewicz, 2017: 94). Although the qualitative content analysis of data is depicted here as a linear process, it is not the case. As the analysis progresses, there is movement back and forth between the text, the researcher's first impressions of the data and the emergence of the categories and themes. This process is called the hermeneutic spiral (Erlingsson & Brysiewicz, 2017: 96).

3.10.1 Immersion in the data

The first step in qualitative data analysis is to become familiar with the data (Gray et al., 2017: 430-431). The interview transcripts and field notes were managed as discussed in 3.9.1. I read and re-read the interview transcripts in order to gain an understanding of what the participants were saying. Each interview transcript was then read again while listening to the audio-recording of the interviews and necessary corrections were made. The field notes and interview transcripts were compared in order to add the non-verbal data (such as expressions and emotions) collected during the interviews. During this time, the transcript of interview four was translated from Afrikaans to English and both versions were compared to see if the data and meanings corresponded.

While listening to the recorded interviews, I could recall the experiences during the semi-structured interviews. This process allowed me to become immersed in the data, since I continuously reflected upon meanings and relationships of the data (Creswell, 2014: 247). I spent an extensive amount of time reading and thinking about the data, which allowed me to formulate thoughts on the key information participants are conveying (Gray et al., 2017: 431; Erlingsson & Brysiewicz, 2017: 94). Comprehensive notes were made about each interview and the transcripts were copied into an Excel spreadsheet as a means of organizing the data (see Appendix 11).

3.10.2 Meaning units

The text was then divided into smaller parts called meaning units. This was achieved by separating each transcript's data line by line in the Excel spreadsheet while keeping the research aim and question in mind.

The researcher shortened the meaning units while ensuring that the key meaning was still clear and intact (Erlingsson & Brysiewicz, 2017: 96). During this process, some meaning units did not necessitate further condensation as it was so compact. The following is an example of a meaning unit and the condensation thereof, as illustrated in **Figure 3.3**:

"Because I felt like a failure, I felt like I'm not a good enough sister, that's the thing. I felt like I was the only one struggling this much to adjust to being a PN; it was a different environment" (**Meaning unit**)

"*felt like a failure, not a good enough sister; felt like only one struggling this much to adjust to being PN; it was a different environment"* (**Condensed meaning unit**)

3.10.3 Formulation of codes

When the condensation of the data was completed, the coding process ensued. Coding is the process of assigning descriptive labels to condensed meaning units (Erlingsson & Brysiewicz, 2017: 96). It facilitates the identification of connections between meaning units (Erlingsson & Brysiewicz, 2017: 96). After the initial coding, codes were compared with the data to check if it corresponds. I then assigned meanings to each code, which led to some data being re-coded. Due to the complexity of the data, coding, re-coding and categorization occurred several times. Furthermore, I continued to make notes of my impressions of and reactions to the text (Erlingsson & Brysiewicz, 2017: 96). The following is an example of a code that was assigned to the condensed meaning unit as shown in **Figure 3.3**:

"Adjustment" (**Code**)

3.10.4 Development of categories and themes

Codes were compared and grouped to form categories. Categories are comprised of codes which appear to deal with similar issues (Erlingsson & Brysiewicz, 2017: 96).

Moreover, categories are manifest content that is visible in the data (Erlingsson & Brysiewicz, 2017: 96-97). At this stage of the analysis, I copied all the codes onto flipchart paper and pasted them on a wall in order to visualize the data (see Appendix 12). After that, I used coloured sticky notes to identify all the codes that appeared to belong together. Codes with the same-coloured sticky notes were grouped together and formed the categories. Category names are usually concise and factual sounding (Erlingsson & Brysiewicz, 2017: 97).

Data was abstracted to a higher level to form themes as it was rich with latent meaning (Erlingsson & Brysiewicz, 2017: 97). Themes are formed by grouping two or more categories together and convey the latent or underlying meaning in the data (Erlingsson & Brysiewicz, 2017: 97). Three overarching themes and eight sub-themes emerged through the data analysis process, which will be identified, discussed and situated in literature in the following chapter. These themes were used to generate the implications of the findings (Creswell, 2014: 249-250). The following are examples of the category formed and theme generated, as depicted in **Figure 3.3**:

"Feeling prepared" (**Category**)

"A complex experience" (**Theme**)

3.11 SUMMARY

In this chapter, I discussed the research design and methodology used in this study. A comprehensive description of the research design and rationale for selecting an exploratory-descriptive qualitative design was presented. Furthermore, a detailed description and discussion of the population, sampling methods, data collection tool, pilot interview and data collection and analysis were provided. The researcher presented how ethical principles and measures were taken to ensure trustworthiness in the study. The next chapter will discuss the findings of the study supported by relevant literature.

CHAPTER 4
FINDINGS

4.1 INTRODUCTION

Chapter 1 provided an outline of this study, while Chapters 2 and 3 described the literature review and research methodology respectively. In this chapter, the researcher presents the findings from the data offered by study participants. The emergence of three overarching themes through the data analysis process is described and discussed. The themes and sub-themes are supported by original quotations from the interview data. The findings are further elaborated on and substantiated using relevant literature.

In this chapter, I provide an overview of the participants' biographical data offered by each participant. A rich description of the study findings, contextualized with relevant literature, then follows.

4.2 SECTION A: BIOGRAPHICAL DATA

The final study sample included five participants. These participants met the inclusion criteria of the study, namely:

- Newly qualified, registered community service nurses with at least six months' clinical experience as community service nurses in an urban district public health facility
- Registered nurses who completed community service no more than 4 months ago at a public health facility

The community service nurses who participated in the study were female and single. Their ages ranged between 20 to 45 years. Most of the participants preferred to speak English during the interviews, but for most participants English was their second language with either Afrikaans or Xhosa being their first language. In terms of race, four participants self-identified as being coloured and the fifth participant self-identified as being black. All of the participants completed their nursing education training at Western Cape College of Nursing. All participants completed six months of community

service at the time of data collection. The following table (Table 4.1) displays the participants' demographic profiles.

Table 4.1 Demographic profiles

Participant No.	Age	Race	Gender	Marital Status	NEI	Community service contractual period
0 (Pilot)	24	Coloured	Female	Single	WCCN	01 Aug 2016 to 31 July 2017
1	36	Coloured	Female	Single	WCCN	01 Feb 2017 to 31 Jan 2018
2	23	Coloured	Female	Single	WCCN	01 Feb 2017 to 31 Jan 2018
4	42	Coloured	Female	Single	WCCN	01 Feb 2017 to 31 Jan 2018
5	24	Black	Female	Single	WCCN	01 Feb 2017 to 31 Jan 2018

4.3 SECTION B: THEMES EMERGING FROM THE INTERVIEWS

The community service nurses who participated in the study had varied experiences during their community service year at the urban district hospital. Three main themes and eight sub-themes emerged through the data analysis process.

4.3.1 Identified themes and sub-themes about newly qualified nurses' experiences of their compulsory community service year at a Cape Town urban district hospital

The first theme describes the varied experiences of the participants during their compulsory community service year. This theme subsequently generated three sub-themes relating to their initial experiences of community service.

The second theme highlighted the participants' experience of the support that they had received, and two sub-themes were then generated.

The third theme describes the positive experiences and challenges the participants encountered in the clinical environment. Three sub-themes emerged from the analyzed data, which describes the participants' experiences of the clinical practice area. Figure 4.1 provides a schematic presentation of the themes and sub-themes.

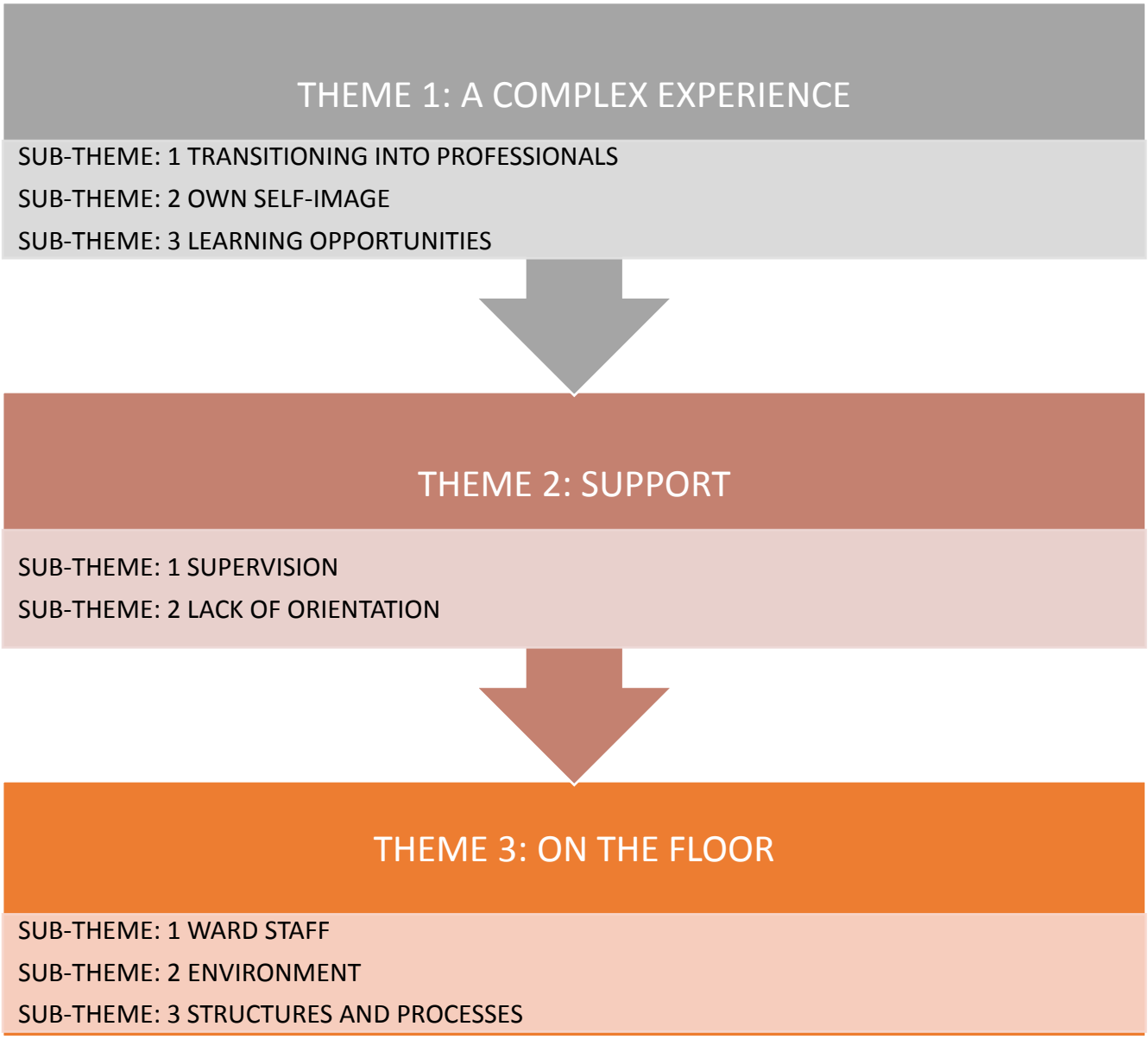


Figure 4.1: Identified themes and sub-themes of newly qualified nurses' experiences

4.3.2 Theme 1: A complex experience

Most of the community service nurses who participated in this study described their community service year as a good experience which they enjoyed. The following sub-themes emerged from this theme: transitioning into professionals, own self-image and learning opportunities. The sub-themes describe the participants' adaptation to their new role and responsibilities.

"I have loved every minute of it… Yeah, the fact that I got my first-choice placement was nice. I chose hospital A because I'd done my training here and I had worked here previously, and it's literally around the corner from home." (Participant 1)

"So, far it's been, hoe sê ons nou, [how do you say] an easy breeze. I haven't like gotten into trouble or anything like that, so for me I think it's been a good experience so far." (Participant 2)

The participants felt that the community service year was beneficial as it enabled them to develop their knowledge and skills before assuming their new role and responsibilities. Other positive factors about the community service year that were identified by participants included working with patients; helpful, pleasant staff; earning a salary; and placement. However, a participant had mixed feelings about the community service year but agreed that it was a good experience. This participant felt that registered nurses who had completed the previous four-year programme without community service were all effective and efficient practitioners but admits that they might not have received the same guidance and support.

"It's a tough one for me because like I said when I first studied com-serve never existed, so all my colleagues that did finish after four years…they've become very successful and competent, registered nurses. So, I have seen it from both sides and it's a difficult one to answer for me because I mean I'm enjoying com-serve year. I am

finding it a year of growth and development…I am finding it a positive experience." (Participant 1)

Govender et al. (2015: 6) had similar results as participants in their study also viewed the community service year as positive. Additionally, Reid et al.'s (2018: 744) 15-year review of community service doctors showed that most respondents had become more positive towards community service over the years.

4.3.2.1 Sub-theme 1: Transitioning into professionals

The transition from student to working professional involved a new role and responsibilities. Newly qualified nurses must adapt to the demands of their new role and responsibilities. Within the findings, there are elements that support and elements that impede their role adaptation. Some participants described that they had fewer responsibilities as students, but now, as community service nurses, they have more responsibilities.

*"…when you're a student it's…you work in this different departments but you don't take responsibility for what's happening in the department, so that huge responsibility, it was also difficult, but not in the sense that I didn't want a responsibility… it was like I wanted to fulfil my role, like I wanted to be competent in what I'm doing." (*Participant 0)

"…mostly just the experience because like when you're a student mos now you don't really feel all the pressure because this is now not done; you're more relaxed. But now…I think I am someone who likes to work under pressure and can handle a pressure or cope in whatever environment." (Participant 2)

"Okay, practically I'm very much hands-on as compared to when I was a student, né…when I get into a ward, I'm expected to do this, for example the diet sheet, my IV list, allocation and everything… So, practically when I was a student, you know, I never bothered myself about those things; I, jonga, it was just my prac book and sister must just sign and then I'm off." (Participant 5)

The participants in a study done by Govender et al. (2017: 18) supported this fact by stating that they were learning their new professional duties through enhanced responsibility and accountability.

A few of the participants in this study were becoming aware of their changing role and status within nursing through professional growth. These participants were learning how to delegate and supervise sub-ordinates.

"…last year when I was doing my fourth year, okay, she's doing her fourth year, just report minimal stuff to her, blah, blah, blah, but now like everything is being reported to me and they're like looking to me to help them or guide them. And okay, sometimes I have to refer back to the senior sister and then have to get back to them on some topics. But I think that also is a plus for doing this year." (Participant 2)

"…at the end of the day I feel as if I'm not acting up to my qualified position or whatsoever… and these perceptions and beliefs that okay, she's older, I can't ask her to do this…or my operational manager was also saying a few months back that at work it's not about age, it's not about colour, it's about position. You must know your position; you must respect the other person's position but also know where you stand and stand your ground." (Participant 5)

These findings are supported by Govender et al. (2017: 18) as their participants reported experiencing professional development through supervising nursing students.

Also, some participants in the current study noted differences between tertiary and district institutions. These differences included the level of care offered, available resources, ward setup and bed capacity. At the same time, participants indicated that there is a difference in learning opportunities at each institution as well. In comparison to tertiary institutions, participants felt that this district hospital allowed a broader scope of practice for community service nurses. Most participants agreed that at tertiary institutions, newly qualified nurses have fewer responsibilities whereas at this district hospital, they were expected to perform as registered nurses.

"…it gives you that space…to get all your…acquire all your skills and knowledge before you are really expected to run a ward. But that's not really applicable in hospital A, because even if you're a community service nurse, you are a RN, you are running the ward alone…Whereas in a tertiary institution…community service would benefit you…I can't really say benefit you more because then there's more sisters on duty and you don't really take the responsibility of being an RN. But in the small setup they

throw you in on the deep side and you just become competent and confident in your skills." (Participant 0)

"Because now you're expected to…like in the ward it's not like you're a com-serve, you're a sister, you are a sister there. It's…there's no game." (Participant 5)

In the same way, Walker et al. (2016: 509) reported a difference in how newly qualified nurses perceived themselves as opposed to what others expected of them. Newly qualified nurses in this study felt that even though they were still transitioning and learning, they were treated as competent and experienced registered nurses (Walker et al., 2016: 509). Similarly, in studies relating to community service, community service nurses were expected to know everything even though they were newly qualified, apprehensive and still lacked confidence (Du Plessis, 2012: 5).

Community service nurses in the current study were expected to manage wards with little practical experience and minimal confidence due to staff shortages and incompetent agency staff.

"I was say three months into com-serve; for the whole weekend I had to manage that whole entire ward alone…I called management, I told them look here, you can't send me an agency sister that knows nothing because I'm not even confident myself in, you know, doing this." (Participant 0)

Walker et al. (2016: 508) supports this finding as newly qualified nurses in their study felt that their responsibilities were greater than their competence level. Also, increased responsibilities result in newly qualified nurses feeling overwhelmed (Govender et al., 2017: 18), which leads to uncertainty, anxiety, stress and reduced confidence (Walker et al., 2016: 508).

On the other hand, some participants in this study welcomed the fact that hospital A allowed community service nurses a broader scope of practice as it increased their confidence in being able to manage wards effectively, as evidenced by the following comments:

"…they really allow you to run an area. The fact that they…like I said, if you are unfamiliar then it will feel like they're cruel for leaving you just like that and they…but I think that it's a positive thing to be thrown in the deep end and then rise and…makes

you responsible and able to cope under pressure…and when it's done, its done and you have confidence in yourself." (Participant 4 - translated)

"I was actually called in to do overtime to replace a registered nurse, so I was called in and I worked with another com-serve for the day… and together and the team of nurses we had with us that day, we worked well together, we had no problems and we left feeling like: oh my gosh, we actually did it you know." (Participant 2)

Similar findings were reported by Govender et al. (2017: 19) as community service nurses were used to replace registered nurses due to staff shortages. Additionally, participants in a study conducted Roziers et al. (2014: 95) expressed feeling more confident after successfully managing wards on their own.

However, Participant 4 also felt that not all community service nurses were able to cope with the increased responsibilities. Adaptation to the new role and increased responsibilities appeared easier for those who had trained at hospital A. However, the same level of performance was expected from newly qualified nurses who were not familiar with this hospital and were left without support to struggle on their own.

"Sink or swim…second year students had to assist the com-serve because they feel that you're supposed to know, and if you don't, they leave you; like make your mistakes and you'll just have to write reports if something happens, understand?" (Participant 4 - translated)

As noted previously, most newly qualified nurses experience uncertainty, reduced confidence levels, increased anxiety and stress (Walker et al., 2016: 508), and fear of the unknown (Roziers et al., 2014: 95-96). Therefore, the transition shock experience is heightened when newly qualified nurses are faced with unrealistic expectations without the appropriate organizational support (Walker et al., 2016: 510).

Furthermore, some participants experienced role confusion, as in some wards, newly qualified community service nurses were permitted to function as registered nurses. *"I just found there I was allowed to work as a registered nurse. I was given a scope, uhm, of actually being the registered nurse and I had a staff nurse and ENAs working with me as a little team"* (Participant 2); whereas certain areas restricted their scope of practice, as newly qualified nurses functioned as staff nurses due to staff shortages, which affected their learning experiences.

"Normally it's a sister and a PN and a staff nurse and the ENA. But then, because the staff nurse went on leave, they did the same with me and another com-serve that finished before me, X. We had to now replace the staff nurses on duty, which I felt was unfair because now you're limiting my scope of practice and I'm here to learn so I have to do the work of a staff nurse; do observations. It's not a problem for me to do it, I will do it gladly, but I mean what am I learning from this experience?" (Participant 0)

Govender et al. (2017: 19) supports these findings as community service nurses in their study were treated as both students and registered nurses in different clinical areas.

Moreover, the transition from student to employed professional was easier for some newly qualified nurses compared to others in this study. One participant reported feeling ignored on the first day and traumatised due to an emergency where a patient who she knew died. Also, many participants experienced anxiety, stress and unhappiness in clinical areas due to staff attitude and behaviour and having to deal with new clinical situations and environments. Participants handled work-related stress and anxiety differently as there was no formal means of debriefing. Some participants chose to remain positive, others used humour to cope with difficult situations and the rest experienced emotional breakdowns either at home or work.

"I hated it in the beginning; I wanted to die and I wanted to end my com-serve, because two months into it I said I can't do this anymore… I felt like a failure, I felt like I'm not a good enough sister, that's the thing. I felt like I was the only one struggling this much to adjust to being a PN; it was a different environment." (Participant 0)

Newly qualified nurses must adapt to the demands of their new role and responsibilities, which affects their health and well-being (Walker et al., 2016: 508). Added stressors such as social isolation and workplace incivility increase newly qualified nurses' susceptibility to physical and mental illness (Walker et al., 2016: 508).

4.3.2.2 Sub-theme 2: Own self-image

All participants expressed optimism, enthusiasm and wanting to make a difference in their new careers upon commencement of the community service year. However, negative transition experiences affected the little confidence community service nurses had when starting the year. Participant 4 viewed herself as someone who is able to convert negative experiences into constructive learning experiences: *"I prepare*

myself mentally: this is a learning process and if I can get past these things, then I'll come out the stronger, and the more I can learn, the better it is for me. So, I convert the whole situation that I see into a positive thing – that is part of my learning." (Participant 4 - translated)

In addition, this participant felt that your personality and attitude determine learning experiences: *"…I feel that a person's personality and a person's attitude enrich your learning. So, because I'm older, I'm not just coming from school—direct from school and then went into training. So, I'm coming from the workplace, so I'm known with the work area and attitudes and things there."* (Participant 4 - translated)

Ankers et al. (2018: 322) also found that older graduates were able to cope better in difficult situations than younger, newly qualified nurses. The authors suggest that life experience can ease transition difficulties (Ankers et al., 2018: 322).

Likewise, one more participant described that dedication and determination are personal motivators for becoming a good registered nurse. In contrast, another participant described that her upbringing, culture and having a weak support system affected her confidence level.

"…my mother, she's an alcoholic…there are many things that I…that she lacks like in her motherly role when it comes to me, and I see that, eish, if maybe she was such a mother, if maybe she would support me in such a way…Whether I pass or fail it's my own problem. So, I…in varsity I had to make sure that I passed regardless or not I'm not going to repeat a year because I am my own self, I am my own motivator, I am my own pushing shove or so whatever, I am my own." (Participant 5). Moreover, her family is financially dependent on her as she is the sole breadwinner. This resulted in self-neglect as her family expects her to provide for them; however, she has become more assertive and has taken action to decrease the financial burden on herself.

Also, this participant explained that her sociocultural background was a barrier to being an effective leader at work: *"…not having like such of a, can I say, like a weak support system, at work you tend to be this…like you're a sister, you're expected to, you know, to run the ward and delegating, but you are like in a shell because you're not motivated to be confident and stand up…for instance you would see maybe like staff nurses, older people, older ENAs here at the hospital like where maybe I'm placed at overrides, overrides, overrides…"* (Participant 5)

Additionally, culture affected workplace relationships and nursing care. Due to her young age, nurses of the same culture as her felt that she was disrespectful when she delegated duties to them: *"…in the working environment makes you feel like or makes you to appear as if you're sort of this person who doesn't have confidence…it's my social background…you mustn't speak to your elder at like a higher tone and you don't tell your elder what to do. And who do you think you are now that wena you are now. Haibo XXX, no, you are young…"* (Participant 5). However, this participant chose her new profession over culture as patient care was being impacted: "*I've decided I'm not going to follow this cultural background because it's just taking me back, it's a stumbling blocking..."* (Participant 5)

These findings are supported by Smith (2017: 18) as the author states that cultural competence involves a self-assessment of one's own understanding of nursing profession motives and goals. It is an evolving process that necessitates a commitment to continuous self-assessment, personal and professional behaviours and experiences that support cultural competence (Smith, 2017: 20). In addition, Stanley, Hayes & Silverman (2014: 153-154) found that nursing students recognized that caring was not about treating the identified culture but about treating the patient.

4.3.2.3 Sub-theme 3: Learning opportunities

All participants agreed that they acquired knowledge, practical skills and critical thinking abilities during the community service year. Newly qualified nurses were able to improve and apply new knowledge and skills, which assisted personal and professional development. Also, participants stated that they gained practical knowledge by asking, observing and doing.

In addition, participants were able to integrate theory learned at nursing education institutions with clinical practice. Furthermore, community service nurses reported learning more in certain wards as they were given more scope to practice independently. The acquisition of new skills included delegation, ward management, prioritization, assertiveness, leadership, conflict management and disciplinary measures. Additionally, learning new skills enhanced the confidence and competence of newly qualified community service nurses. Most participants considered it beneficial that hospital A allows a broader scope of practice as they could acquire knowledge.

Moreover, most participants reported having enough learning opportunities such as in-service training, doctors' rounds as well as teaching from registered nurses.

However, community service nurses described that they missed out on some learning opportunities due to staff shortages and busy wards. Although some staff were willing to teach, they did not always have the time to answer questions due to increased workloads.

"So, I think that really limited you in some sense because they're constantly short of staff so you couldn't always go on training, which I love doing, you couldn't always listen, do the doctors' rounds or attend the doctors' rounds, you couldn't always sit in with these meetings which I love to do because you can't; there's no time, there's absolutely no time." (Participant 0)

"…I think at times I would say the wards get so crazy busy that sometimes we don't have the time to ask questions, or have assistance from another staff member because they have got that to do and you know they are busy with this and busy with that. It's not often at all, so ja, I have just found that sometimes we are short-staffed, and everyone is busy with what they are doing that they don't have time to assist." (Participant 1)

Some participants felt that nursing education institutions (NEIs) must include practical skills such as conflict management and leadership during their training, as the work environment differs from theory. These practical skills could assist with building confidence in newly qualified nurses.

"So, for me, it's like if maybe leadership skills…would be added. Ja, because those…are the things that I needed like in order to be a good leader. I'm coming from a home whereby there was none of that, like, there was none, none, none, none. I had to find my own way out you see? And then, now I'm in the working field and here it's completely different. I must be a leader, and no one cares where you grew up or if it was your mother or what. They just expect you to do or act…" (Participant 5)

These findings are consistent with that of other studies (Ankers et al., 2017: 321; Walker et al., 2016: 509; Theisen & Sandau, 2013: 409) in which newly qualified nurses expressed that, although they are academically prepared for practice, universities need to include more practical nursing skills to equip nurses to cope with

the actual clinical circumstances. In addition, newly qualified nurses would be able to handle difficult workplace interpersonal relations if they are equipped with skills such as conflict management (Walker et al., 2016: 310). Also, newly qualified nurses have the potential to become effective leaders if they possess leadership qualities (Theisen & Sandau, 2013: 408).

Many newly qualified community service nurses had the opportunity to develop their critical thinking skills and decision-making abilities.

"…if I have a problem, she will first ask me what do I think that I must do. Then I will tell her okay, this is the problem, I think we must go that way and then she'll support it if she sees it's…Or she would tell me don't you think this way is much easier or better for right now and then we implement your plan just a little later, like that." (Participant 2)

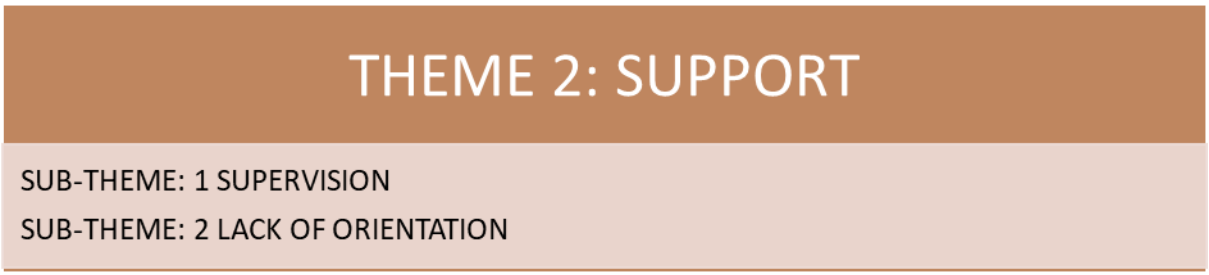
"I'll definitely say no because hospital A allows you to think critically as they put you in a position where you have to think critically, they'll put you in a position where you feel that you won't make it but you just have to make it to get through the day." (Participant 4 - translated)

According to Kaihlanen, Salminen, Flinkman & Haavisto (2016: 4), new qualified nurses were able to familiarize themselves with clinical decision-making by practicing independently and having responsibilities, which supports the findings of the current study. Furthermore, Theisen & Sandau (2013: 409) assert that critical thinking is a competency that newly qualified nurses need to be able to cope with the current healthcare climate.

Most participants reported being open to learning from all staff and valued constructive criticism. Additionally, participants stated that the support received from doctors and nursing staff as well as having respect for all categories of staff facilitated the learning experience. Also, community service nurses' own optimistic attitude towards learning has contributed to having a positive experience.

"…I'm eager to learn, that's why I respect people that are lower than me, like category-wise, because I believe that I can learn something from them also, that's another thing. They can still teach me and they are really allowed to teach me, so I'm just open to anyone who say, no, don't do this, this is how it's done." (Participant 5)

4.3.3 Theme 2: Support



The participants reported receiving varied support in different clinical practice areas. Many participants described receiving good support and guidance from operational managers, registered nurses, the multidisciplinary team, administrative staff, some nursing staff and each other. However, the same participants also described receiving minimal or no support in other clinical environments. Theme 2 describes the support strategies in place for community service nurses and encompasses the sub-themes *supervision* and *lack of orientation*.

Support and guidance provided by experienced operational managers and registered nurses increased the confidence and competence of newly qualified community service nurses. Also, some operational managers facilitated community service nurses' learning experience by creating an environment conducive to learning and providing encouragement.

In addition, registered nurses contributed to the development of knowledge and skills of novice community service nurses by teaching and being helpful. Furthermore, community service nurses valued the support and mutual respect shown by some clinical staff.

"People are more sort of understanding and lenient towards…if they know are a community service nurse because they know you're fresh out of college and you obviously don't or won't have the abilities like a registered professional nurse." (Participant 0)

"…just having a support system and knowing that I can lean on them if I need something done, that's also a nice feeling." (Participant 2)

"Another shift leader that I worked with and this other operational manager I'm working with now, she's very supportive in boosting…But what she's working on is boosting my inner side, my… [confidence]." (Participant 5)

"I can only say that there are sisters who really take you by the hand and show you the finer details of running a ward smoothly, I had that. There's a sister who literally told you that you're now done with that, come and sit here so I can talk to you a little on how to handle certain situations..." (Participant 4 - translated)

"I have had phenomenal sisters, not to mention any names, but they have been great… uhm…and they have really helped develop, you know, my skills this year and even the person I am. Some of them are like don't even pay attention to that and something that I would focus on and make a big thing, they like, no, don't even go there. You know they have been really helpful." (Participant 1)

Community service nurses received adequate support and guidance from registered nurses, which facilitated their transition from student to working professionals (Govender et al., 2015: 7). Constructive feedback and encouragement assisted in the growth of confidence, which eased the fear and uncertainty associated with transition (Govender et al., 2015: 7; Kaihlanen et al., 2016: 4).

However, a few nurse managers were not always supportive towards newly qualified community service nurses. Some nurse managers ignored complaints about unprofessional staff behaviour and incompetent agency staff. Also, community service nurses received no support when being re-allocated to work in other clinical areas.

"Spoke to the operational manager about it, she did nothing about it. Even if I say: 'But look here,' she can go on her side of the ward rounds and I am going to go on my side then she's like, no, she's already on the ward round and that's just how it is." (Participant 0)

"There was a case when I started here that I myself didn't know what to do…So, I asked another sister who I felt comfortable with, because I didn't want to approach the matron as I wasn't sure what the matron would say to me, like: 'Sister, but why don't you know this or that?' So, I didn't feel comfortable to…because one of the people that was with me said: 'So why don't you call the matron if you don't know?' So I said that I won't take that chance because I've heard stuff already that they come down on you." (Participant 4 - translated)

Walker et al. (2016: 510) reported similar findings where staff shortages, increased workloads and the absence of organizational support placed additional pressure on

newly qualified nurses. Newly qualified nurses in Ankers et al. (2017: 322) identified staff at unit level who were friendly and eager to assist them.

4.3.3.1 Sub-theme 1: Supervision

Most of the newly qualified community service nurses received adequate clinical supervision. Several community service nurses reported that they could function independently by managing wards on their own with support at hand.

"… I feel like she has confidence in me because she trusts me to like run a ward or whatever. She will tell me: 'Okay, XXX, today I'm just going to do admin work, you can just sort all of this out for me.' And then later, when I'm done with everything, like she will just come and say: 'Do you need help with anything, do you need me to explain anything?' and it will go from there." (Participant 2)

"…I have found since I have been here, I have been in really nice wards with registered nurses who were very willing to teach and, you know, show me the ropes and have the patience to guide me through the actual process, which is nice. So in the beginning, you know, they're with you all the time and you don't feel alone or lost and they give you the space as well to work independently…I have had a lot of support as well through the whole journey." (Participant 1)

According to Netshisaulu & Maputle (2018: 4), supervision is key in assimilating theory and clinical practice and enhances newly qualified nurses' competence in providing safe and efficient care.

On the other hand, while some participants received satisfactory supervision, others were left to struggle on their own. Some participants described having no support or supervision when re-allocated to work in other areas or working with incompetent agency registered nurses. A successful ending to a workday was based on no negative patient incidents and crises.

"You're thrown into an area where you're struggling to adjust and there's no one that checks up on you, saying: 'But I will…' They won't come, and…they will leave you just like that, ask if you're all right but then just continue." (Participant 4 - translated)

"As the com-serve, you're told that you're working with the agency and remember that you're the superior, so you have to run the show…So, we run the show because its

expected of us to do it…there's no one to tell you, that comes to see if you've survived, the day just passed, and you handed over and so the day passed. You feel that you've survived…there was no crisis, a patient did not fall from the bed or the wrong medication wasn't administered or something." (Participant 4 - translated)

4.3.3.2 Sub-theme 2: Lack of orientation

Orientation to new clinical environments is important in easing newly qualified nurses' transition from student to working professional (Phillips et al., 2013: 109-110). However, one participant in this study reported that orientation in new wards only occur after a few weeks of being there. Staff seems reluctant to orientate new community service nurses and only do so because they are obligated.

Newly qualified nurses are eager to learn, but nurses are not keen on teaching, which leaves them to cope on their own without really knowing processes (Ankers et al., 2017: 322-323). Also, community service nurses have restricted access to resources, which affects the performance of duties. Therefore, community service nurses orientate each other to new areas to familiarize themselves with ward functions and procedures.

"But if you're coming into a new place and left alone and they want to see what you're made of…you have to struggle for the first, second, third day before they give some sort of orientation, just to cover themselves to the fact that you were orientated, understand? There's no real in-depth where someone takes you by the hand and walk you through it, but I do it." (Participant 4 - translated)

The current study found that a lack of orientation has a negative impact on transition to practice, which was confirmed by various other studies (Parker et al., 2011: 1415; Flinkman & Salantera, 2014: 1054; Govender et al., 2015: 6-7; Walker et al., 2016: 510; Ankers et al., 2017: 322). Poor orientation reduced the confidence and competence of newly qualified nurses, since this left them feeling doubtful, abandoned and fearful of making critical errors (Flinkman & Salantera, 2014: 1054). Satisfactory orientation is required to assist newly qualified nurses in adapting to new environments so that they can perform effectively and efficiently (Thopola et al., 2013: 174).

4.3.4 Theme 3: On the floor

Newly qualified nurses are rotated through various clinical areas to gain practical experience. Participants in this study had different experiences in each clinical rotation. Most participants described certain clinical environments as challenging due to staff attitudes and behaviour; incompetent agency staff; and uncertainty about policies and procedures. The following comment summarized this theme:

"…but now, on the floor, that's where the problem is, on the floor." (Participant 5)

This theme generated the following sub-themes: ward staff; environment; and structures and processes.

4.3.4.1 Sub-theme 1: Ward staff

Community service nurses in this study had both positive and negative experiences with ward staff. Participants valued the unit staff who were friendly, helpful and caring. On the other hand, all participants reported negative incidents involving ward staff. Furthermore, newly qualified nurses described feeling victimized, bullied and disrespected by unit staff. In addition, community service nurses did not always receive support from nurse managers when reporting fellow nurses' behaviour. The following are some of the participants' comments:

"…when I went to ward Y, which was the worst possible placement that I could ever have in hospital A, the operational manager was fine, but I felt like she was more on the permanent staff's side and she didn't see the things that they did – like deliberately did – to spite me or to bully me… that sister would deliberately go on my ward rounds and then she won't hand over to me…she did all the time." (Participant 0)

Similarly, participants in Mammen et al. (2018: 594) experienced being treated as if they were invisible or irrelevant.

"…I got home that evening and the other com-serve who handed over phoned me in tears, she's like: 'Oh my gosh, you will not believe what happened, she was nitpicking and saying we didn't do anything right and the ward was upside down,' and she just took it totally out of control and you know it was just not the truth, but she made the other com-serve feel very sort of victimized, and I took offence because I know how we left the ward and what was done and what wasn't." (Participant 1)

Mammen et al. (2018: 594) reported similar results where participants expressed being scrutinized and judged by permanent staff. The authors assert that this type of behaviour from experienced staff can destroy the confidence levels of newly qualified nurses, cause medical errors and therefore affect patient care (Mammen et al., 2018: 594).

"…my experiences were not all happy, there were times that I can say, yes, because a person gets to deal with nurses that…I don't know if they feel threatened by a person's presence like…that I got mostly, not from the sisters but from ENAs and staff nurses…So many times they have the attitude that we have been here longer than you, you don't know anything, you know very little because we have to teach you in…and—but you are now above us." (Participant 4)

Additionally, language was used to isolate community service nurses: *"They would all speak in Xhosa because they were all and then they would like deliberately do things to put me in a bad light."* (Participant 0)

In contrast, one participant felt victimized by a senior manager: *"I think the matron is my challenge; she's very scary…She's just on my case basically…And she just forever gets me on the wrong time. It's like she's looking for me like in everything."* (Participant 2)

Negative work environments are barriers to successful transition of newly qualified nurses to the workplace. Unprofessional behaviour from nursing peers are particularly damaging to newly qualified nurses, as they are in part socialized by experienced nurses (Vogelpohl et al., 2013: 419-420; Hofler & Thomas, 2016: 134). The findings in the current study are supported by numerous other research findings explaining the consequences of negative work environments, such as professional and social isolation (Kelly & Ahern, 2008: 913-914; Walker et al., 2016: 509; Ankers et al., 2017: 322), rejection by unit staff (Thopola et al., 2013: 177; Du Plessis, 2012: 5-6),

workplace incivility (Mammen et al., 2018: 594-595) and bullying (Vogelpohl et al., 2013: 414-422).

Furthermore, negative interpersonal interactions affect the negligible confidence of newly qualified nurses, which increases uncertainty about their knowledge and clinical practice (Mammen et al., 2018: 594). Failure of hospital management to protect nursing staff from unprofessional workplace behaviour means that they are condoning these harmful behaviours (Hofler & Thomas, 2016: 134).

4.3.4.2 Sub-theme 2: Environment

Most participants in this study described the areas that they worked in as being busy and short-staffed, which increase the nursing workload. As noted before, busy wards and staff shortages negatively affected learning opportunities. Staff shortages were often the result of absenteeism. Participant 0 stated the following: *"I can't see how this is a coincidence because the one weekend Sister X left 12 o'clock; nurse A took sick for the whole weekend, the nurse, the RN… took sick for the whole weekend and then the ENA also took off sick that one weekend. The staff nurse went on bereavement leave which is completely understandable…"*

According to Thopola et al. (2013: 175-176), nursing staff shortages resulted in a lack of support due to the absence of registered nurses on the shifts where community service nurses are present.

Agency nursing staff are sometimes used to relieve staff shortages. However, many participants complained about the quality of agency registered nurses that are sent by nursing agencies, as evidenced by the following comments: "*That agency sister was more a hazard than anything else, because she asked me: 'Can I mix my IVs with your needle?' So, you know, that already tells me a lot… complete disaster, knew nothing"* (Participant 0). Another participant stated: *"The agency sisters…I don't know where these people did their training. It's kind of strange to see that people who have been working for an agency for some time don't know the basic stuff…"* (Participant 4 - translated)

Incompetent agency registered nurses increase workload challenges as community service nurses have to complete the tasks that they are supposed to do. Participant 4 added the following: *"And the saddest of all is that although you're the com-serve, because you're familiar with the hospital and especially those of us who trained here,*

they have confidence in us because they know our capabilities, so we're just told, excuse that person, we couldn't find anyone else, but run the ward, stand in for that person." (Participant 4 – translated)

Newly qualified nurses are expected to assume the role and responsibilities of an experienced professional nurse due to nursing staff shortages and incompetent agency registered nurses. Staff shortages affect the level of patient care provided (Flinkman & Salantera, 2014: 1053), and unreasonable workloads have a detrimental effect on newly qualified nurses as they may suffer from burnout and fatigue (Thopola et al., 2013: 176; Flinkman & Salantera: 2014: 1053).

Furthermore, several participants agreed that operational managers in each ward had different management styles, which affected the clinical environment. Some nursing managers created an environment conducive to learning by providing support and guidance, whereas others' management styles resulted in poor practice environments.

"But now, in this other placement that I was at, what I didn't like, it didn't sit right with me, is like having this authoritative operational manager on you. You just don't want to do wrong… because she's jor, shouting and she can make the whole ward routine chaotic…And when she's gone 4 o'clock…you do feel a difference, even in your working performance you don't do any mistake…" (Participant 5)

"You know sometimes I find, especially as unit managers, if you want to address a situation, then do it in private, don't blow a gasket and scream and shout in front of patients and the other staff members." (Participant 1)

"They like to scream and shout and just crit you and sometimes publicly…" (Participant 2)

During the community service year, newly qualified nurses are still learning the norms, attitudes, behaviours, skills, roles and values of the nursing profession (Kuan Lai & Hong Lim, 2012: 32). Nursing managers and registered nurses are usually the staff that newly qualified nurses look up to. In addition, positive role modelling assists in the successful professional socialization of newly qualified nurses (Kelly & Ahern, 2008: 914). Nursing managers in a study conducted by Govender et al. (2016: 65) stated that they must lead by example in order to guide newly qualified nurses in becoming good professional nurses. Nurse managers also said that newly qualified nurses compelled them to behave in the correct manner (Govender et al., 2016: 65).

4.3.4.3 Sub-theme 3: Structures and processes

Participants expressed their frustration concerning the uncertainty of institutional policies and procedures. This was an added stressor during the initial months of transitioning. Clinical rotation was applied inconsistently for community service nurses. Some participants were allocated to a ward for two to three months, while others did six months at a time. The following comments were shared by participants:

"I didn't know the hospital policies; I didn't know the way that they did things, so that was hectic. And then from there I was in ward Z like for two and a half months, so that was just finding my feet." (Participant 0)

"It's good that they change all the departments in this year because…okay, say this six months I've been in medical, now I feel like I don't know anything about surgical stuff." (Participant 2)

Newly qualified professionals in their community service year are exposed to new work environments each time they are rotated through different clinical areas. Clinical rotation is crucial for increasing the competence, knowledge and clinical skills of newly qualified nurses (Kelly & Ahern, 2008: 915). However, each new clinical rotation produces reality shock for newly qualified nurses, as they experience renewed anxiety and stress (Roziers et al., 2014: 97; Kelly & Ahern, 2008: 915).

Furthermore, some participants experienced challenges with ward staff who were not rotated on a regular basis, which affected their placements.

"…some people…fall in a certain area and that's their area…They are not rotated from there, so what I'm saying is that if you're new, then you're just thrown in wherever someone don't want to work or where it's too hectic to work…" (Participant 4 - translated)

Newly qualified nurses become aware of specific inequalities in the community service year after assuming their new professional roles. Inequalities in rotations, rosters and workloads are part of a nursing culture that novice graduates discover during this time (Kelly & Ahern, 2008: 913).

Another challenge that community service nurses seem to face upon completion of the community service year is unemployment. One participant verbalized that newly qualified nurses have difficulty finding employment after the year is completed.

"*...you struggle to get a job after community service because, like, Hospital A, they don't have to employ RNs, like, unless a permanent RN resigns because they get community service nurses all the time…so there's no need for them to hire permanent staff because they rely on this community service nurses, which is a problem because we don't get jobs afterwards…That's the only reason why I don't like community service, the unemployment afterwards."* (Participant 0)

Hospital management depends on community service officers as human resources due to budgetary constraints (Reid et al., 2018: 745-746). Although community service seems to be an effective recruitment policy, it does not ensure the growth of an effective, long-term workforce unless other measures are instituted (Reid et al., 2018: 745).

4.4 SUMMARY

In this chapter, the findings of the study were presented in relation to the research question. The three main emergent themes and eight sub-themes were described and discussed. The first theme, a complex experience, described the varied experiences of the participants during their compulsory community service year. The second theme, support, highlighted the participants' experience of the support that they had received, and the third theme, on the floor, described the positive experiences and challenges the participants encountered in the clinical environment.

The three overarching themes each generated sub-themes that were discussed in detail and supported with quotes from the interview data. The findings were further elaborated on and substantiated with relevant literature. In Chapter 5, I will discuss the findings in relation to the conceptual framework of the study. Valid conclusions and recommendations will be made about newly qualified nurses' experiences of their compulsory community service year at a Cape Town urban district hospital.

CHAPTER 5
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 1 provided an outline of this study, whereas Chapters 2 and 3 described the literature review and research methodology respectively. In Chapter 4, the findings of the study, based on the data offered by participants, were presented. Three overarching themes and eight sub-themes emerged through the data analysis process, which were supported by quotations from the interview data and substantiated with relevant literature.

In this final chapter, the findings are discussed in relation to the conceptual framework of the study. The study's limitations are discussed, and valid conclusions and recommendations are made about newly qualified nurses' experiences of their compulsory community service year at a Cape Town urban district hospital. The chapter is concluded with an outline of how the research study will be disseminated, and an overall study conclusion is provided.

5.2 DISCUSSION

The discussion section of a study connects the findings of the study to prior literature. Links between the findings and the conceptual framework of the study, including other literature, are therefore made (Lobiondo-Wood & Haber, 2014: 104). The findings are the focus and is discussed in detail in order to make sense of it (Brink et al., 2018: 189). The purpose of this study was to explore and describe newly qualified nurses' experiences of the compulsory community service year at an urban district hospital. The following discussion offers an integration of the findings, the research problem and objectives to address the study phenomenon (Brink et al., 2018: 188). The findings are discussed in relation to each study objective.

5.2.1 Objective 1: Explore newly qualified nurses' experiences of community service

The participants' experience of compulsory community service was complex. Community service nurses in this study saw compulsory community service as an opportunity for gaining further knowledge and skills before assuming the new role and responsibilities of a registered professional nurse and is similar to the findings in Thopola et al. (2013: 177) and Govender et al. (2017: 17).

Most participants in the current study had a good overall experience; however, positive experiences were sometimes negated by various negative elements. Positive factors included working with patients, amiable and supportive staff, receiving a salary and first-choice placements. These findings are consistent with Govender et al. (2015: 6) and Reid et al. (2018: 744) as participants in these studies viewed the community service year as a positive experience. Similarly, Roziers et al. (2014: 95-96) and Du Plessis (2012: 17-19) found that constructive feedback, acknowledgement from staff and being treated as colleagues and peers improved the transition experiences of community service nurses.

Community service nurses in the current study recognized that the role transition from student to practicing professionals involved increased responsibilities to which they had to adapt. These findings are supported by Govender et al. (2017: 18) whose study showed that community service nurses viewed the compulsory community service year as a period in which new professional duties can be learned through enhanced responsibility and accountability. However, Govender et al. (2017: 18) further revealed that community service nurses were overwhelmed by being given too much responsibility too soon. Similarly, Walker et al. (2016: 509) describes how newly qualified nurses were treated as competent and experienced nurses whereas they were still transitioning and learning.

In the setting of this study, the nature and services of the urban district hospital allows for a broader scope of practice for community service nurses. As such, novice community service nurses were expected to perform as experienced nurses with full responsibilities; expected to be knowledgeable about everything even though they were newly qualified, inexperienced and still lacked confidence. Duchscher's

Transition Shock Theory affirms that newly qualified nurses experience shock after the completion of orientation when faced with their full responsibilities and workload (Duchscher, 2009: 1109). Community service nurses must assume professional responsibilities that are beyond their capabilities which intensifies the experience of reality shock and role transition (Flinkman & Salantera, 2014: 1054; Govender et al., 2015: 5-8).

Community service nurses in this study managed wards with minimal practical experience and confidence that was further undermined due to staff shortages and incompetent agency staff. Community service nurses are used to replace registered professional nurses in public hospitals due to staff shortages (Govender et al., 2017: 19). Staff shortages increase the nursing workload and novice community service nurses feel overwhelmed as they find themselves having to be in charge of wards (Roziers et al., 2014: 97; Govender et al., 2015: 5). Within the Transition Shock Theory (Duchscher, 2009: 1107), newly qualified nurses feared rejection by peers and colleagues should they be exposed as being incompetent, insecure practitioners incapable of coping with their new roles and responsibilities.

Newly qualified nurses are unprepared for the amount of responsibility given to them (Govender et al., 2017: 18). They feel that too much responsibility can decrease their self-confidence (Govender et al., 2017: 18). They furthermore have to make decisions, even though they have limited clinical experience, which is extremely stressful (McCalla-Graham & De Gagne, 2014: 125). Newly qualified nurses commence their first year of clinical practice with basic knowledge and skills learned during their training (McCalla-Graham & De Gagne, 2014: 124-125) but are challenged beyond their beginner skill set due to staff shortages (Hofler & Thomas, 2016: 133; Flinkman & Salantera, 2014: 1053; Roziers et al., 2014: 96). Increased responsibilities result in newly qualified nurses feeling overwhelmed, which leads to doubt, anxiety, stress and reduced confidence (Roziers et al.,2014: 97; Govender et al., 2015: 5; Walker et al., 2016: 508). In contrast, newly qualified nurses who feel confident about their clinical competence experience less work stress than those who are not confident in their clinical competence (Cheng et al., 2014: 413).

In this study, the increased scope of practice was welcomed by some community service nurses, as it made them confident in managing wards. Similarly, newly

qualified nurses in Roziers et al. (2014: 95) and Walker et al. (2016: 510) were able to manage wards successfully, which led to professional development and increased confidence.

In this current study, role adaptation and increased responsibilities were easier for community service nurses who trained at this urban district hospital. However, performance expectations were the same for those who were unfamiliar with the facility and they were left to struggle on their own. Duchscher (2009: 1106) theorizes that unrealistic performance expectations by newly qualified nurses, co-workers and healthcare institutions influence the amount of stress experienced by newly qualified nurses. Newly qualified nurses experience uncertainty, decreased confidence, heightened anxiety and stress (Walker et al., 2016: 508) and fear of the unknown (Roziers et al., 2014: 96-96). Thus, the transition shock experience is increased when newly qualified nurses are faced with unrealistic performance expectations without receiving the appropriate organizational support (Khunou, 2019: 6-9; Walker et al., 2016: 510).

Community service nurses in this research experienced role confusion, as, due to staff shortages, they performed as registered professional nurses in some clinical areas and as staff nurses in others. This affected their learning experiences. These findings are consistent with Govender et al. (2017: 19), as community service nurses functioned as both registered professional nurses and students in various clinical areas.

In this study, role transition and adaptation were easier for some newly qualified nurses than others. Community service nurses utilized different coping mechanisms, such as humour and maintaining a positive mindset, in dealing with transition experiences, while others suffered emotional breakdowns. These findings are consistent with Duchscher's Transition Shock Theory (2009: 1106), as the author described the first stage of role transition as being intense and filled with overwhelming emotions for newly qualified nurses. High levels of stress and anxiety in the first few weeks of transitioning to clinical practice result in newly qualified nurses feeling scared and shocked. Similarly, in studies associated with community service, these findings can be seen in Khunou (2019: 6-9); Abiodun et al. (2019: 8); Du Plessis (2012: 4-6); Thopola et al. (2013: 173) and Roziers et al. (2014: 95-96). Newly qualified nurses

must adapt to the demands of their new role and responsibilities, which affects their health and well-being (Walker et al., 2016: 508). Added stressors such as social isolation and workplace incivility increase newly qualified nurses' susceptibility to physical and mental illness (Walker et al., 2016: 508).

5.2.2 Objective 2: Describe these experiences in relation to knowledge, practical skills, critical thinking abilities and professional behaviour development

Newly qualified nurses in this study acquired knowledge, practical skills and critical thinking abilities and developed their professional behaviour in the community service year. They could integrate theoretical knowledge with clinical practice, which assisted in personal and professional development. Newly qualified nurses in Duchscher (2009: 1109) said that the new role built on prior knowledge and skills and that the process was similar to yearly advances as students. Similarly, the community service year provided newly qualified nurses in Govender et al. (2017: 17) with an opportunity to assimilate nursing education into clinical practice through gaining experience. The integration of theory and practice is facilitated by adequate clinical supervision, which increases community service nurses' competence (Netshisaulu & Maputle, 2018: 4).

Community service nurses in the current study found it beneficial that this facility allowed a broad scope of practice, as they learned and developed more through independent practice. According to Duchscher (2009: 1108), newly qualified nurses develop into more mature, professional people who establishes their professional identities. Similarly, Du Plessis (2012: 3) and Roziers et al. (2014: 95) described that independent practice upon commencement of the community service year produced feelings of joy, excitement and satisfaction in community service nurses. Professional growth and maturity in the new role were met with enthusiasm (Roziers et al., 2014: 95). Newly qualified nurses realized that they had entered the professional world and must behave accordingly by being responsible and accountable (Govender et al., 2017: 17-18). Newly qualified nurses' confidence in clinical practice improves as ward routines become familiar and tasks are completed in time (Ankers et al., 2017: 322).

Community service nurses in this research acquired new skills such as delegation, supervision, unit management, prioritization, assertiveness, leadership, conflict

management and disciplinary procedures. The learning of new skills increased the confidence and competence of novice community service nurses. Likewise, community service nurses in Govender et al. (2015: 6) and Govender et al. (2017: 18) developed professionally by improving their knowledge and skills through clinical rotation and exposure to added responsibilities such as unit management and student supervision. Practical skills such as leadership, conflict resolution, time management and prioritization are required for effective and efficient clinical practice (Theisen & Sandau, 2013: 409; Walker et al., 2016: 508).

Newly qualified nurses in this study had sufficient learning opportunities such as in-service training, doctors' rounds as well as teaching and guidance from registered professional nurses. In contrast, newly qualified nurses in Duchscher's (2009: 1106-1109) study feared being regarded as incompetent if they constantly requested assistance from their colleagues. Experienced nurses make newly qualified nurses feel inept and slow (Mammen et al., 2018: 594), which affects their participation in ward activities. Most newly qualified nurses avoid participating in ward discussions, doctors' rounds and handover rounds, as they are unsure of how colleagues perceive their competence (Thrysoe et al., 2011: 554).

Community service nurses in this research missed out on some learning opportunities due to busy wards and staff shortages. Staff were willing to teach but did not always have the time to answer questions due to everyone's increased workloads. These findings are consistent with Duchscher (2009: 1109) who found that newly qualified nurses did not easily approach senior nurses as everyone carried a heavy workload. Although community service nurses in Roziers et al. (2014: 95) and Govender et al. (2017: 18) did not dread asking questions of senior nursing staff, other community service nurses experienced difficulties. These newly qualified nurses identified approachable and supportive staff who could assist them (McCalla-Graham & De Gagne, 2015: 125; Ankers et al., 2017: 322). On the other hand, nurse managers and senior nurses were frustrated by the amount of supervision required by novice community service nurses (Govender et al., 2016: 65; Netshisaulu & Maputle, 2018: 4-5).

Community service nurses in this study had to assume the role and responsibilities of experienced nurses due to staff shortages and incompetent agency registered

professional nurses. Increased workloads due to staff shortages result in fatigue and burnout in newly qualified nurses and affect staff retention (McCalla-Graham & De Gagne, 2015: 125; Flinkman & Salantera, 2014: 1053-1055; Laschinger et al., 2012: 1273). Duchscher (2009: 1107) explains that newly qualified nurses experience exhaustion by the third to fourth month of transition as a result of trying to cope with adapting to the clinical environment. Newly qualified nurses understand their vulnerability due to insufficient practical knowledge, skills and experience but use internal personal strengths and support systems to overcome challenges and accomplish self-actualization (Mammen et al., 2018: 595). In striving for self-actualization, they learn independently and become self-reliant (Mammen et al., 2018: 595).

Newly qualified nurses in this work stated that NEIs must include practical skills such as leadership and conflict management in their training as the clinical environment differs from theory. These findings are consistent with Ankers et al. (2017: 321), Walker et al. (2013: 509) and Theisen & Sandau (2013: 409), as newly qualified nurses in these studies expressed that, although they are academically prepared for practice, universities need to include more practical nursing skills so that they can cope with the actual clinical circumstances. Walker et al. (2016: 310) further argue that newly qualified nurses will be able to handle difficult workplace interpersonal interactions should they be equipped with skills such as conflict management.

Newly qualified nurses in the current study had opportunities to develop clinical decision-making skills and critical thinking abilities. Theisen & Sandau (2013: 409) assert that newly qualified nurses must be able to think critically and make informed clinical decisions. Community service nurses in this study were open to learning and valued constructive criticism. These findings are supported by Phillips et al. (2013: 109) and Roziers et al. (2014: 95), as provision of positive feedback from nurse managers about newly qualified nurses' clinical performance increases their confidence and competence, which play an important role in successful transitioning. Likewise, community service nurses' willingness to perform professional duties is appreciated by nurse managers, as it indicates that they want to learn more (Govender 2016: 64). Positive support from nurse managers and clinical support staff motivates improved performance (McCalla-Graham & De Gagne, 2014: 125).

In this work, support and mutual respect from staff facilitated community service nurses' learning experiences. Du Plessis (2012: 4) and Thrysoe et al. (2011: 553) support these findings as newly qualified nurses feel valued when they are consulted and can contribute their knowledge and skills.

5.2.3 Objective 3: Identify facilitators and barriers that influence a newly qualified nurse in developing knowledge, practical skills, critical thinking abilities and professional behaviours during the community service year

The findings show that there are both facilitators and barriers that seem to influence a person's experience of the community service year.

5.2.3.1 Facilitators:

Community service nurses in the current study expressed optimism, enthusiasm and wanting to make a difference in their new careers upon commencing the community service year. These findings are consistent with that of Duchscher (2009: 1109) who found that newly qualified nurses were keen and excited to assume their new professional role, which felt familiar to them as they compared it to their clinical rotations as students.

Newly qualified nurses in this study identified that dedication, determination, being open to learning and having a positive attitude and good personality contributed to a positive experience. Other studies (Mammen et al., 2018: 594; Roziers et al., 2014: 95; Du Plessis, 2012: 3) also support these findings, as their participants were positive, passionate, confident, excited and proud of their new professional title.

Community service nurses in this work valued the support, guidance and mutual respect received from nursing staff and the rest of the interdisciplinary team. Good support and acceptance by senior colleagues have a positive effect on newly qualified nurses' transition experience (Duchscher, 2009: 1106). Support for newly qualified health professionals has been identified in various studies across professions as being essential to successful transitioning to practice (Edwards et al., 2015: 1267; Missen et al., 2014: 2430; Parker et al., 2011: 1411-1418; Thopola et al., 2013: 169-181; Hatcher et al., 2014: 1-14; Govender et al., 2015: 1-8). Key indicators to successful transitioning of newly qualified nurses involve respect from senior colleagues,

performance feedback and recognition of good work performance (Phillips et al., 2013: 108-110). Mutual professional and social interaction enhance the experience of being valued and accepted as part of the work community (Thrysoe et al., 2011: 555; Du Plessis: 2012: 17-19; Parker et al., 2011: 1413).

In this study, support from experienced operational managers and registered professional nurses enhanced the confidence and competence of newly qualified nurses. Constructive feedback, the development of self-confidence and being accepted as part of the nursing team enhance positive transition experiences of newly qualified nurses (Matlhaba et al., 2019: 4; Craig et al., 2012: 207; Roziers et al, 2014: 95-96).

In the current study, some operational managers facilitated newly qualified nurses' learning experience by providing encouragement and creating environments conducive to learning. Registered professional nurses contributed to the development of knowledge and skills of newly qualified nurses by teaching and being helpful. Good clinical supervision enabled community service nurses to function independently. One participant felt that being an older novice community service nurse with previous work experience aided the transition experience. Ankers et al. (2018: 322) support these findings, as older newly qualified nurses in their study were more apt at defending themselves during difficult situations than younger newly qualified nurses were. The authors offer that life experience can ease transition difficulties (Ankers et al., 2018: 322).

5.2.3.2 Barriers:

Negative factors that impeded community service nurses' experience of the community service year include a lack of support and orientation, negative staff attitude and behaviour and dealing with new clinical situations and environments.

- *Lack of support and orientation*

A lack of orientation to new clinical environments in this study resulted in newly qualified nurses having to cope without knowing the appropriate policies and procedures. Phillips et al. (2013: 108-109); Flinkman & Salantera (2014: 1054); Thopola et al. (2013: 173-174); Govender et al. (2015: 5) and Khunou (2019: 6-7) also

found that poor orientation affects the ability of newly qualified nurses to effectively adapt to new clinical environments. The transition shock experience is intensified when newly qualified nurses are left alone in units without adequate orientation (Ankers et al., 2017: 322; Thopola et al., 2013: 173-174), which leaves them feeling doubtful, abandoned and fearful of making fatal errors (Flinkman & Salantera, 2014: 1054).

Newly qualified nurses in this study only received orientation to new wards after a few weeks from reluctant staff who only complied because they were duty-bound. Community service nurses supported each other by providing verbal orientation before their clinical rotations. Duchscher (2009: 1109) claims that newly qualified nurses' difficulty in adjusting to increased responsibilities can be attributed to managers', senior nurses' and clinical educators' approaches to orientation. Senior nursing staff and clinical educators fail to understand the competence level of newly qualified nurses and expect them to function as experienced nurses within a short period of time (Duchscher, 2009: 1109). They expect community service nurses to be competent and able to practice independently (Netshisaulu & Maputle, 2018: 4), even though most newly qualified nurses still lack confidence in their basic clinical skills (Matlhaba et al., 2019: 5; Burke et al., 2014: 1286). Nurse managers recognize that community service nurses require orientation and supervision in the first months of transition (Govender et al., 2016: 66-67); however, other nurse managers feel that it requires a lot of work to get newly qualified nurses to an acceptable and safe practice standard (Burke et al., 2014: 1286).

Newly qualified nurses in the current study received no support from nurse managers in having to deal with unprofessional staff behaviour, incompetent agency staff and being re-allocated to work in other clinical areas without adequate supervision. These findings are consistent with Phillips et al. (2013: 109) and Flinkman & Salantera (2014: 1054) who found that newly qualified nurses received no support from nurse managers and colleagues when dealing with unprofessional staff. Newly qualified nurses in Phillips et al. (2013: 109) expressed that respect was determined by the nursing culture and environment (Phillips et al., 2013: 109). Reid et al. (2018: 747) assert that orientation, support from management and clinical supervision are essential for the effective functioning of community service practitioners in the clinical environment.

- *Staff attitude and behaviour*

Novice community service nurses in this study described being victimized, bullied and disrespected by ward staff. Language was also used as a means of isolating novice community service nurses. According to Duchscher (2009: 1106-1107), newly qualified nurses seek validation, reassurance, protective nurturing and positive reinforcement from colleagues. However, difficult collegial relationships have been identified as having a negative influence on newly qualified nurses' confidence level (Duchscher, 2009: 1106-1107). Likewise, hostility and a lack of respect from colleagues undermine newly qualified nurses' practice and confidence (Phillips et al., 2013: 109; Walker et al., 2016: 509).

One participant in this study identified a lack of personal support and culture as barriers that affected her confidence level and leadership ability. Smith (2017: 18) explains that cultural competence involves a self-assessment of one's own understanding of nursing profession motives and goals. Therefore, a commitment to continuous self-reflection, personal and professional behaviours and experiences that support cultural competence is required (Smith, 2017: 20).

Young community service nurses in this study experienced difficulties with older nursing staff. Young, newly qualified nurses struggle to gain respect from older, experienced staff, which negatively affects communication and ultimately patient care (Phillips et al., 2013: 109; Thopola et al., 2013: 174-175). Being called names, undermined (Khunou, 2019: 7), ignored and disrespected (Du Plessis, 2012: 36; Thrysoe et al., 2011: 554) are all barriers to effective communication.

Most literature has identified nursing peers as the likely culprits of bullying. Unprofessional behaviour from experienced nurses are particularly damaging to newly qualified nurses, as they are partly responsible for the socialization of newly qualified nurses (Du Plessis, 2012: 22-35; Thopola et al., 2013: 177; Roziers et al., 2014: 96; Vogelpohl et al., 2013: 419-420; Hofler & Thomas, 2016: 134). Unsupportive and uncivil work environments (Mammen et al., 2018: 594-595); rejection by ward staff (Thopola et al., 2013: 177; Du Plessis, 2012: 5-6); professional and social isolation (Walker et al., 2016: 509; Ankers et al., 2017: 322); and bullying by experienced nurses (Vogelpohl et al., 2013: 414-422) influence the professional socialization of newly

qualified nurses negatively and have an adverse effect on patient care as the risk of clinical errors increase (Mammen et al., 2018: 594-595). Negative work environments are barriers to the successful transitioning of community service nurses to the clinical practice area, as the experience of reality shock is thereby increased (Roziers et al., 2014: 97).

- *New clinical situations and environments*

Busy wards and staff shortages increased the workload and affected newly qualified nurses' learning opportunities in this study. Incompetent agency registered professional nurses were an added burden on community service nurses' workload challenges. Govender et al. (2015: 1) and Roziers et al. (2014: 92) also found that community service nurses are placed in public health facilities that are already understaffed. In Thopola et al. (2013: 175-176), nursing staff shortages resulted in a lack of support, since registered professional nurses were not available to guide community service nurses. The high number of patients compared to nurses are additional stressors, as newly qualified nurses are not used to providing nursing care to a large number of patients in their student years (Abiodun et al., 2019: 8-9).

Clinical rotations of community service nurses in this study were inconsistent, with some community nurses rotating on a three-month basis and others only rotating after six months. Permanent staff were not rotated regularly, which affected the placements of newly qualified nurses. Clinical rotation is essential in developing the competence, knowledge and practical skills of newly qualified nurses (Matlhaba et al., 2019: 6).

Upon completion of the community service year, newly qualified nurses face the additional challenge of unemployment as verbalized by one study participant. The current global health climate has seen a decline in the nursing workforce, leading to nursing shortages; therefore, the retention of newly qualified nurses is crucial (Missen et al., 2014: 2420). Due to budgetary constraints, hospital managements depend on community service nurses as human resources (Reid et al., 2018: 745-746). While community service appears to be an effective recruitment policy, it does not guarantee the development of an effective, long-term workforce (Reid et al., 2018: 745). Other measures are therefore needed.

5.3 LIMITATIONS OF THE STUDY

A discussion of the limitations of the study follows.

- This qualitative study was conducted in a single health institution in the Western Cape and the experiences of community service nurses in other healthcare instituions could potentially add greater depth or alternatives to the findings.
- The participant group in this study was homogenous in terms of race and gender which could mean that a more heterogenous group of participants in terms of their race and gender may have offered further nuance to the findings.

5.4 CONCLUSIONS

The research question of this study was answered by analyzing the rich, in-depth experiences of the participants. Community service nurses had varied experiences of the community service year. The overall experience was positive, with community service nurses being able to develop their knowledge, practical skills, critical thinking abilities and professional behaviour. Their experiences identified specific facilitators and barriers that influence newly qualified nurses' experience of the community service year.

5.5 RECOMMENDATIONS

The following recommendations, based on the findings of the study, can be made. The recommendations are intended for practice, NEIs and further research.

5.5.1 Recommendations for nursing practice

- Newly qualified community service nurses must work with experienced registered professional nurses on a shift.
- Newly qualified community service nurses must be treated as transitioning nurses.
- Nursing management should allow community service nurses enough time to gain sufficient clinical experience and confidence before requiring them to manage wards on their own.
- The scope of practice of community service nurses should be clearly defined.

- Although an EAP is available to community service nurses, nursing management should investigate debriefing measures for clinical situations at ward level.
- Workplace incivility policies should be established and staff should be held accountable for transgressions.
- Nursing management and other staff should be more supportive towards transitioning community service nurses.
- Orientation should occur within the first week of clinical practice.
- Nursing management should liaise with nursing agencies regarding their staff's performance and should query their experience.

5.5.2 Recommendations for NEIs

- NEIs should include practical simulations of real-life situations such as conflict management.
- Other practical skills that should be included are leadership skills and disciplinary measures.

5.5.3 Future research

The following research areas should be explored in future studies:

- Further studies that include a more heterogenous group of participants in terms of race and gender;
- the experiences of newly qualified nurses at more than one urban district hospital;
- the experiences of newly qualified nurses at other levels of care, for example tertiary and primary healthcare facilities; and
- workplace incivility and its effects on nurses.

5.6 DISSEMINATION

The results of this research study will be presented at the Nursing and Midwifery Research Day. The participating hospital will also be presented with a copy of the study.

5.7 CONCLUSION

The purpose of this study was to explore and describe newly qualified nurses' experiences of the compulsory community service year at an urban district hospital. Three overarching themes and eight sub-themes were generated from participants' experiences. These findings assisted in identifying the components of the community service year that contributed to and those that detracted from the development of knowledge, practical skills, critical thinking abilities and professional behaviour in newly qualified nurses. Recommendations for nursing practice and nursing education institutions have been provided to possibly inform a review and revision of current support strategies for newly qualified nurses doing community service in public urban facilities.

APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

23-Mar-2017
Scheepers, Vanessa VC

Ethics Reference #: S17/02/031

Title: **Exploring newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals.**

Dear Mrs Vanessa Scheepers,

The **New Application** received on **08-Feb-2017**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **16-Mar-2017** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **23-Mar-2017 -22-Mar-2018**

Please remember to use your **protocol number** (**S17/02/031**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel:

+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at .

Included Documents:
Checklist(Eng)_V2.1 April 2016.doc
Declaration V Scheepers.pdf
V Scheepers Curriculum Vitae.docx
Application form_0001.pdf
JBell_CV_short_feb2017.pdf
Proposal Synopsis February 2017.docx
Protocol.docx
Application form_signature page.pdf
Declaration J Bell.pdf

Sincerely,

Franklin Weber
HREC Coordinator
Health Research Ethics Committee 1

Appendix 2: Progress report approval from Stellenbosch University

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Progress Report
Approval Letter

05/02/2019

Project Reference #: 8763

Ethics Reference #: S17/02/031

Title: Exploring newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals

Dear Mrs Vanessa Scheepers ,

Your request for extension/annual renewal of ethics approval dated 04/02/2019 15:45 refers.

The Health Research Ethics Committee reviewed and approved the annual progress report you submitted through an expedited review process.

The approval of this project is extended for a further year.

Approval date: 18 December 2018

Expiry date: 17 December 2019

Kindly be reminded to submit progress reports two (2) months before expiry date.

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your **Project ID** [8763] and Ethics Reference Number S17/02/031 on any documents or correspondence with the HREC concerning your research protocol.

Yours sincerely,

Mrs. Melody Shana,

Coordinator,

HREC1,

National Health Research Ethics Council (NHREC) Registration Numbers: REC-130408-012 for HREC1 and REC-230208-010 for HREC2

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005240 for HREC1

Institutional Review Board (IRB) Number: IRB0005239 for HREC2

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African

Page 1 of 2

Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Department of Health).

APPENDIX 3: PERMISSION FROM DEPARTMENT OF HEALTH

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2017RP35_863
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University

Private Bag X1

Matieland

Stellenbosch

7602

For attention: Mrs Vanessa Scheepers, Dr Janet Bell

Re: **Exploring newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals.**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Victoria Hospital	**Patrick Jeftha**	**021 799 1125**
Karl Bremer Hospital	**Iris Adams**	**021 918 1318**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of

completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AJ HAWKRIDGE

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 24/5/2017.

APPENDIX 4: PERMISSION OBTAINED FROM INSTITUTION

Vanessa Scheepers

From: Vanessa Scheepers <vscheepers10@gmail.com>
Sent: Monday, November 11, 2019 11:36 PM
To: Vanessa Scheepers
Subject: Fwd: WC_2017RP35_863

---------- Forwarded message ---------
From: **Nasief van der schyff** <nasief@gmail.com>
Date: Thu, May 11, 2017, 10:58 PM
Subject: Re: WC_2017RP35_863
To: Vanessa Scheepers <vscheepers10@gmail.com>
Cc: Bell, Janet <jbell@sun.ac.za> <jbell@sun.ac.za>

Good Day

Thank you for contacting me.

Can you please tell me a little bit of your research so that I may be to advise you further.

Regards
Dr N van der Schyff

On Thu, May 11, 2017 at 9:25 AM, Vanessa Scheepers <vscheepers10@gmail.com> wrote:
Good day, Dr van der Schyff

My name is Vanessa Scheepers, currently a student in the Master of Nursing programme at Stellenbosch University, fullfilling the second year requirements of conducting a research project.

Referring to the email below from Josh-Lee Kroukamp of WC Health and Research, can you please advise with regards to a convenient date and time for me to present my intended research study to you?

Kind regards

Vanessa Scheepers
---------- Forwarded message ----------
From: "Josh-Lee Kroukamp" <Josh-Lee.Kroukamp@westerncape.gov.za>
Date: 11 May 2017 09:07
Subject: WC_2017RP35_863
To: "Vanessa Scheepers" <vscheepers10@gmail.com>
Cc: "Health Research" <Health.Research@westerncape.gov.za>, "Nasief van der schyff (nasief@gmail.com) (nasief@gmail.com)" <nasief@gmail.com>

Dear Vanessa

APPENDIX 5: PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT: Exploring newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals.

REFERENCE NUMBER: S17/02/031

PRINCIPAL INVESTIGATOR: Mrs. Vanessa Scheepers

ADDRESS: Division of Nursing

Faculty of Medicine and Health Sciences

Stellenbosch University

PO Box 241

Cape Town

8000

CONTACT NUMBER: 021 9389823/ 9036

Dear Colleague

My name is Vanessa Scheepers and I am a student in the Master of Nursing programme at Stellenbosch University. I would like to invite you to participate in a research project that aims to explore and describe newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

This research project aims to explore and describe newly qualified nurses' experiences of their community service year at two urban district hospitals.

The study will be conducted at two Cape Town urban district hospitals. Study participants will be selected from all registered community service nurses working at the two urban district hospitals who had completed a four-year nursing programme. The researcher will schedule information sessions about the project at both hospitals and will include both day and night shifts. Consent forms will be handed out during these sessions and completed forms will be collected by the researcher. Only eligible community service nurses will be considered for the study. Community service nurses who meet the following criteria will be asked to participate: newly qualified registered community service nurses with at least six (6) months' clinical experience as a community service nurse in an urban district hospital; registered nurses who completed community service no more than 4 months previously at an urban district hospital.

Interviews, which will be more conversational in nature, will be conducted to obtain information about the research topic. Each interview will last between 45 minutes and 1 hour. Follow-up interviews with permission from the Ethics committee and the participant will be arranged if further information or explanations are required. Interview questions have been piloted at one of the study settings to ensure that it is appropriate and results are consistent. The study's findings will be shared with the participating hospitals.

The reason why you, as a participant have been invited to participate in this study is that you fit the sample criteria. You are an ideal choice as the study involves newly qualified nurses who is either currently fulfilling the compulsory community service requirement or have completed it and is therefore able to provide the best information about the topic.

There are no personal benefits involved for you as the participant; however, the findings of the study can benefit future community service nurses. There are no physical risks involved but there could be some emotional risk, especially when sharing traumatic or upsetting experiences.

All the information collected will be kept private and confidential. Code names will be assigned to protect your identity as well as that of the hospital during data collection, analysis and report writing. Only the researcher and the supervisor of the project will have access to data.

You will not be paid to participate in the study but your transport and meal costs will be covered for each study visit. There will be no costs involved for you if you do take part.

You can contact Mrs. V Scheepers at 081 4978493 if you have any further queries or encounter any problems. You can also contact the Health Research Ethics Committee at 021 9389207 if you have any concerns or complaints that have not been adequately addressed by the principal investigator. You will receive a copy of this information and consent form for your own records.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the investigator or field worker.

Yours sincerely

Vanessa Scheepers

Principal Investigator

Declaration by participant

By signing below, I ……..…….. agree to take part in a research study entitled **"Exploring newly qualified nurses' experiences of their compulsory community service year at two urban district hospitals".**

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. On (*date*) ……...…….. 2017.

.....

Signature of participant

APPENDIX 6: TRANSLATED COPIES OF PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

DEELNEMERINLIGTINGSBLAD

TITEL VAN DIE NAVORSINGSPROJEK: ’n Ondersoek na pas gekwalifiseerde verpleegkundiges se ervaring van hulle gemeenskapsdiensjaar by twee stedelike distrikshospitale

VERWYSINGSNOMMER: S17/02/031

HOOFNAVORSER: Mev Vanessa Scheepers

ADRES: Afdeling Verpleegkunde

Fakulteit Geneeskunde en Gesondheidswetenskappe

Universiteit Stellenbosch

Posbus 241

Kaapstad

8000

KONTAKNOMMER: 021 938 9823/9036

Beste kollega

My naam is Vanessa Scheepers en ek is ’n magisterstudent in Verpleegkunde aan die Universiteit Stellenbosch. Ek wil jou graag nooi om deel te neem aan ’n navorsingsprojek wat beoog om pas gekwalifiseerde verpleegkundiges se ervaring van hulle verpligte gemeenskapsdiensjaar by twee stedelike distrikshospitale te ondersoek en te beskryf.

Die inligting wat hier aangebied word, verduidelik die besonderhede van hierdie projek. Lees dit asseblief en kontak my gerus indien ek enige aspek van die studie verder moet verduidelik of opklaar. Onthou ook, jou deelname is **heeltemal vrywillig** en jy mag weier om deel te neem. As jy besluit om nié deel te neem nie, sal dit hoegenaamd geen slegte gevolge vir jou inhou nie. Jy kan ook in enige

stadium aan die projek onttrek, selfs al het jy aan die begin ingestem om deel te neem.

Hierdie studie is goedgekeur deur die Gesondheidsnavorsingsetiekkomitee (GNEK) van die Universiteit Stellenbosch en sal uitgevoer word ooreenkomstig aanvaarde en toepaslike nasionale en internasionale etiekriglyne en -beginsels, onder meer dié van die Internasionale Verklaring van Helsinki van Oktober 2008.

Met die navorsingsprojek wil ek pas gekwalifiseerde verpleegkundiges se ervaring van hulle gemeenskapsdiensjaar by twee stedelike distrikshospitale ondersoek en beskryf.

Die studie sal by twee distrikshospitale in Kaapstad uitgevoer word. Studiedeelnemers sal gekies word uit alle geregistreerde gemeenskapsdiensverpleegkundiges wat by die twee hospitale werk en wat ’n vier jaar lange verpleegkundeprogram voltooi het. Ek sal by albei hospitale inligtingsessies oor die projek aanbied, wat sowel dag- as nagskofte sal insluit. Gedurende hierdie sessies sal ek toestemmingsvorms uitdeel en ingevulde vorms insamel. Slegs daardie gemeenskapsdiensverpleegkundiges wat aan die studiekriteria voldoen, sal vir die studie in aanmerking geneem word. Die volgende kriteria sal geld: pas gekwalifiseerde geregistreerde gemeenskapsdiensverpleegkundiges met ten minste ses (6) maande kliniese ondervinding as ’n gemeenskapsdiensverpleegkundige in ’n stedelike distrikshospitaal, of geregistreerde verpleegkundiges wat hoogstens vier maande vantevore gemeenskapsdiens by ’n stedelike distrikshospitaal voltooi het.

Onderhoude sal gevoer word om inligting oor die navorsingsonderwerp te verkry. Die onderhoude sal in ’n gemaklike gesprekstyl plaasvind. Elke onderhoud sal tussen 45 minute en ’n uur duur. Met die etiekkomitee en die deelnemer se toestemming sal opvolgonderhoude gereël word indien verdere inligting of verduideliking nodig is. Onderhoudvrae is reeds by een van die studieterreine getoets om te sorg dat dit gepas is en konsekwente resultate oplewer. Die bevindinge van die studie sal aan die deelnemende hospitale bekend gemaak word.

Ek nooi jou om aan die studie deel te neem omdat jy aan die kriteria vir die steekproef voldoen. Jy is ’n ideale keuse, want die studie gaan oor pas gekwalifiseerde verpleegkundiges wat hetsy besig is met hulle verpligte gemeenskapsdiens of dit onlangs voltooi het, en wat ons dus die beste inligting oor die onderwerp kan gee.

Jou deelname aan die studie sal geen persoonlike voordeel vir jou inhou nie. Tog sal toekomstige gemeenskapsdiensverpleegkundiges by die studiebevindinge baat vind. Studiedeelname hou geen fisiese risiko in nie, maar daar kan ’n mate van emosionele risiko wees, veral indien jy oor traumatiese of ontstellende ervarings moet praat.

Alle inligting wat ek insamel, sal privaat en vertroulik gehou word. Jou identiteit sowel as die identiteit van die hospitaal sal gedurende datainsameling, -ontleding en -verslagdoening met ’n kodenaam beskerm word. Slegs ek en die studieleier van die projek sal na die data kan kyk.

Jy sal nie betaal word om aan die studie deel te neem nie, maar ons sal jou vervoer- en etekoste vir elke studiebesoek dek. Dit sal jou niks kos om deel te neem nie.

Kontak my gerus by 081 497 8493 vir enige verdere vrae, of indien jy enige probleme met die studie ervaar. As jy voel dat jou probleme of klagtes nie na wense hanteer word nie, kan jy ook die Gesondheidsnavorsingsetiekkomitee by 021 938 9207 bel. Jy sal ’n afskrif van hierdie inligtingsblad en toestemmingsvorm kry vir jou eie gebruik.

Indien jy bereid is om aan hierdie studie deel te neem, onderteken asseblief die ingeslote toestemmingsvorm en dien dit by my of die veldwerker in.

Vriendelike groete

Vanessa Scheepers

Hoofnavorser

Verklaring deur deelnemer

Deur hieronder te teken, stem ek, ……..……., in om deel te neem aan ’n navorsingstudie getiteld: **“’n Ondersoek na pas gekwalifiseerde verpleegkundiges se ervaring van hulle gemeenskapsdiensjaar by twee stedelike distrikshospitale”.**

Ek verklaar soos volg:

- Ek het die ingeslote inligtingsblad gelees en dit is geskryf in ’n taal waarin ek vaardig en gemaklik is.
- Ek het geleentheid gekry om vrae te stel, en ál my vrae is goed genoeg beantwoord.
- Ek verstaan dat ek **vrywillig** aan hierdie studie deelneem, en niemand het my gedwing om deel te neem nie.
- Ek besef ek kan die studie op enige tydstip verlaat sonder dat ek enigsins gestraf of benadeel sal word.
- Ek besef ek kan gevra word om die studie te verlaat voordat dit klaar is indien die navorser voel dit is in my belang, of as ek nie die studieplan volg waaroor daar ooreengekom is nie.

Geteken te (*plek*) .....…….. op (*datum*) ……...…….. 2017.

.....

Handtekening van deelnemer

INCWADANA YENGCACISO YOMTHABATHI-NXAXHEBA

ISIHLOKO SEPROJEKTHI YOPHANDO: Ukuphonononga amava wabongi abasanda kuvunywa ngokubhekiselele kunyaka wabo onyanzelekileyo wokukhonza uluntu kwizibhedlele ezimbini zesithili ezisezidolophini.

INOMBOLO YESALATHISI: S17/02/031

UMPHANDI OYINTLOKO: Nksk. Vanessa Scheepers

IDILESI: Division of Nursing

Faculty of Medicine and Health Sciences

Stellenbosch University

PO Box 241

Cape Town

8000

INOMBOLO YOQHAGAMSHELWANO: 021 9389823/ 9036

Mlingane Othandekayo

Igama lam nguVanessa Scheepers kwaye ndingumfundi kwizifundo zeMastasi yoKonga kwiYunivesiti yaseStellenbosch. Ndinqwenela ukukumemela ukuthabatha inxaxheba kwiprojekthi yophando enjongo yayo ikukuphononongа nokuchaza amava abongi abasanda kuvunywa ngokubhekiselele kwinkonzo yabo enyanzelekileyo yonyaka yokukhonza uluntu kwizibhedlele ezimbini zesithili ezisezidolophini.

Nceda uthabathe ixesha lakho ukufunda iinkcukacha ezibekwe apha, eziza kukucacisela ngeenkcukacha zale projekthi kwaye ungaqhagamshelana nam ukuba ufuna enye ingcaciso nakowuphi na umba kolu phando. Kwakhona, ukuthabatha kwakho inxaxheba **ukwenza ngokuzithandela ngokupheleleyo** kwaye uvumelekile ukuba ungarhoxa ekuthabatheni inxaxheba. Ukuba uthi hayi, oku akuyi kukuchaphazela kakubi nangayiphi na indlela. Kananjalo ukhululekile

ukuba ungarhoxa kolu phando nanini na, nokuba uyavuma ukuthabatha inxaxheba.

Olu phando luvunyiwe yiKomiti yeeNdlela zokuziPhatha ngokuseSikweni kuPhando lwezeMpilo lweYunivesithi yaseStellenbosch yaye luza kwenziwa ngokwezikhokelo neenqobo zeendlela zokuziphatha zeSizwe nezeZizwe ezamkelekileyo nezisebenzayo, kuquka ezo zesiBhegezo samazwe ngamazwe saseHelsinki sikaOktobha 2008.

Le projekthi yophando inenjongo yokuphonononga nokuchaza amava abongi abasanda kuvunywa ngokubhekiselele kwinkonzo yabo yonyaka kwizibhedlele ezimbini zesithili ezisezidolophini.

Uphando luya kuqhutywa kwizibhedlele ezimbini zesithili ezisezidolophini kwisiXeko saseKapa. Abathabathi-nxaxheba bophando baya kukhethwa kubo bonke abongi ababhalisiweyo beenkonzo zoluntu abasebenza kwezo zibhedlele zimbini zesithili ezisezidolophini, bongi abo bagqibe izifundo zokonga zeminyaka emine. Umphandi uya kucwangcisa iiseshini zengcaciso malunga nale projekthi kuzo zombini ezo zibhedlele yaye uya kubandakanya abo basebenza emini nabo basebenza ebusuku. Iifomu zokuvuma ziya kukhutshwa kwezo seshini yaye iifomu ezigcwalisiweyo ziya kuqokelelwa ngumphandi. Ngabongi benkonzo yoluntu abakulungeleyo ukuthabatha inxaxheba kuphela abaya kuqwalaselelwa olu phando. Abongi benkonzo yoluntu abanezi nqobo zilandelayo baya kucelwa ukuba bathabathe inxaxheba: abongi ababhalisiweyo abasanda kuvunywa benkonzo yoluntu abaneminyaka emithandathu (6) ubuncinane besebenza kwezonyango njengomongi wenkonzo yoluntu kwisibhedlele sesithili esisezidolophini; abongi ababhalisiweyo abagqibe iinyanga ezingaphezu kwesi-4 ngaphambili kwisibhedlele sesithili esisezidolophini.

Kuya kuqhutywa iinkqubo zodliwano-ndlebe ezikumila kufana nencoko ngenjongo yokufumana ingcaciso malunga nesi sihloko sophando. Inkqubo nganye yodliwano-ndlebe iya kuthabatha ixesha elingangemizuzu engama-45 ukuya kwiyure e-1. Kuya kulungiselelwa iinkqubo zodliwano-ndlebe ezilandelayo eziya kuqhutywa ngemvume yekomiti yokuziPhatha ngokuseSikweni nomthabathi-nxaxheba ukuba kukho ngcaciso yimbi okanye kucaciselwa kumbi okufunekayo. Imibuzo yodliwano-ndlebe ilingiwe kwesinye isakhelo sophando ukuqinisekisa

ukuba ifanelekile kwaye neziphumo zayo zizinzile. Okufunyenweyo kuphando kuya kwabelwana ngako nezibhedlele ezithabatha inxaxheba.

Isizathu sokuba wena umenywe njengomthabathi-nxaxheba, ukuba uthabathe inxaxheba kolu phando kukuba ufunyenwe unazo iinqobo ezichaziweyo. Ukufanele ukukhethwa njengoko olu phando lubandakanya abongi abasanda kuvunywa aba kungoku-nje bafezekisa ummiselo wokunyanzeleka ukukhonza uluntu okanye uyifezekisile loo mimiselo yaye ngoko unako ukubonelela ngeyona ngcaciso iyiyo malunga nesi sihloko.

Akukho nzuzo uza kuyifumana njengomthabathi-nxaxheba; kodwa, okufunyaniswe kuphando kungabayinzuzo kubongi benkonzo yoluntu bexesha elizayo. Akukho ngxaki zamzimba ezibandakanyekayo, kodwa zingaba khona zona ezimalunga nemvakalelo, ngakumbi xa kusabelwana ngamava avisa ubuhlungu nakhathazekisayo.

Zonke iinkcukacha eziqokelelweyo ziza kugcinwa zingezangasese kwaye ziyimfihlo ngokunjalo. Uya kunikwa igama eligqwethiweyo ukuze kukhuselwe ukuba wena ungubani nokuba isibhedlele sisiphi ngelixa kuqokelelwa ulwazi, kuhlalutywa kananjalo kubhalwa ingxelo. Ngumphandi kunye nosuphavayiza kuphela weprojekthi oya kufikelela kulwazi.

Awuyi kuhlawulwa ngokuthabatha inxaxheba kolu phando kodwa uya kuzinikwa iindleko zakho zothutho nezokutya kutyelelo lophononongo ngalunye. Akuyi kubakho zindleko zibandakanyekayo ezimele ukuhlawulwa nguwe ukuba ngaba uthabathe inxaxheba.

Ungaqhagamshelana noNksk. V Scheepers kule nombolo yomnxeba 081 4978493 ukuba unayo nayiphi eminye imibuzo okanye uhlangana nazo naziphi na ingxaki kuphando. Kananjalo ungaqhagamshelana neKomiti yeeNdlela zokuziPhatha kuPhando lwezeMpilo ku-021 938 9207 ukuba kukho nantoni na ekuxhalabisayo okanye ekukhalazisayo engaqwalaselwanga ngokwaneleyo ngumphandi oyintloko. Uza kufumana ikopi yale ngcaciso nefomu yokunika imvume ukwenzela ukuba uzigcinele yona.

Ukuba uzimisele ukuthabatha inxaxheba kolu phononongo nceda utyikitye isiBhengezo sokuVuma esiqhotyoshelwe apha usinike umphandi okanye umsebenzi wophando.

Owakho wenene

Vanessa Scheepers

Umphandi Oyintloko

Isibhengezo somthabathi-nxaxheba

Ngokutyikitya apha ngezantsi, mna ……..……. ndiyavuma ukuthabatha inxaxheba kuphando olusihloko sithi: **“Ukuphonononga amava abongi abasanda kuvunywa ngokubhekiselele kunyaka wabo wokukhonza uluntu kwizibhedlele ezimbini zesithili ezisezidolophini ”.**

Ndibhengeza ukuba:

- Ndiyifundile ingcaciso ekule ncwadana iqhotyoshelwe apha kwaye ibhalwe ngolwimi endilwaziyo nendiziva ndikhululekile kulo.
- Ndiye ndalifumana ithuba lokubuza imibuzo kwaye yonke imibuzo yam iphendulwe ngokwanelisayo.
- Ndiyaqonda ukuba ukuthabatha kwam inxaxheba kolu phando ndikwenza **ngokuzithandela** kwaye khange ndinyanzeliswe ukuba ndithabathe inxaxheba.
- Ndingakhetha ukuyeka kuphando nanini na kwaye andiyi kohlwaywa okanye ndicalulwe nangayiphi na indlela.
- Ndisengacelwa ukuba ndilushiye uphando phambi kokuba lugqitywe, ukuba umphandi ucinga ukuba loo nto iya kuba luncedo kum, okanye ukuba andisilandeli isicwangciso somsebenzi wophando ekuvunyelwene ngaso.

Kutyikityelwe (*indawo*).....……..…….. ngomhla (*umhla*) ……...…….. 2017.

.....

Ukutyikitya kwalowo uthabatha inxaxheba

APPENDIX 7: SEMI-STRUCTURED INTERVIEW GUIDE

Interview guide
Date: Place: Interviewer: Interviewee:
Instructions to interviewer: Greet interviewee in a friendly manner and provide explanations about the purpose and structure of the interview, including how long the interview will be. Address the terms of confidentiality with the interviewee. Remain open, courteous and neutral throughout the interview. Allow the interviewee sufficient time to respond to questions and prompt only when required. Inform the interviewee how to contact you afterwards, should they need to. Before you commence with the interview, ask the interviewee if they have any questions. Thank the interviewee for their time and participation at the end of the interview.
Question 1 Could you please tell me about your experiences of and during your community service year? Probes: • What are some of your reasons for liking/ disliking it? • Can you explain further….? • Can you give me an example….?

Question 2

How do you think the community service year is useful in developing the knowledge and skills you require as a registered nurse?

Probes:

- You mentioned….Could you tell me more about that?
- I am not sure what you mean by…
- Could you give me some examples?

Question 3

What assisted you in developing your knowledge, practical skills, critical thinking abilities and professional behaviour during the community service year?

Probes:

- Can you elaborate….?
- Can you give me some examples…..?

Question 4

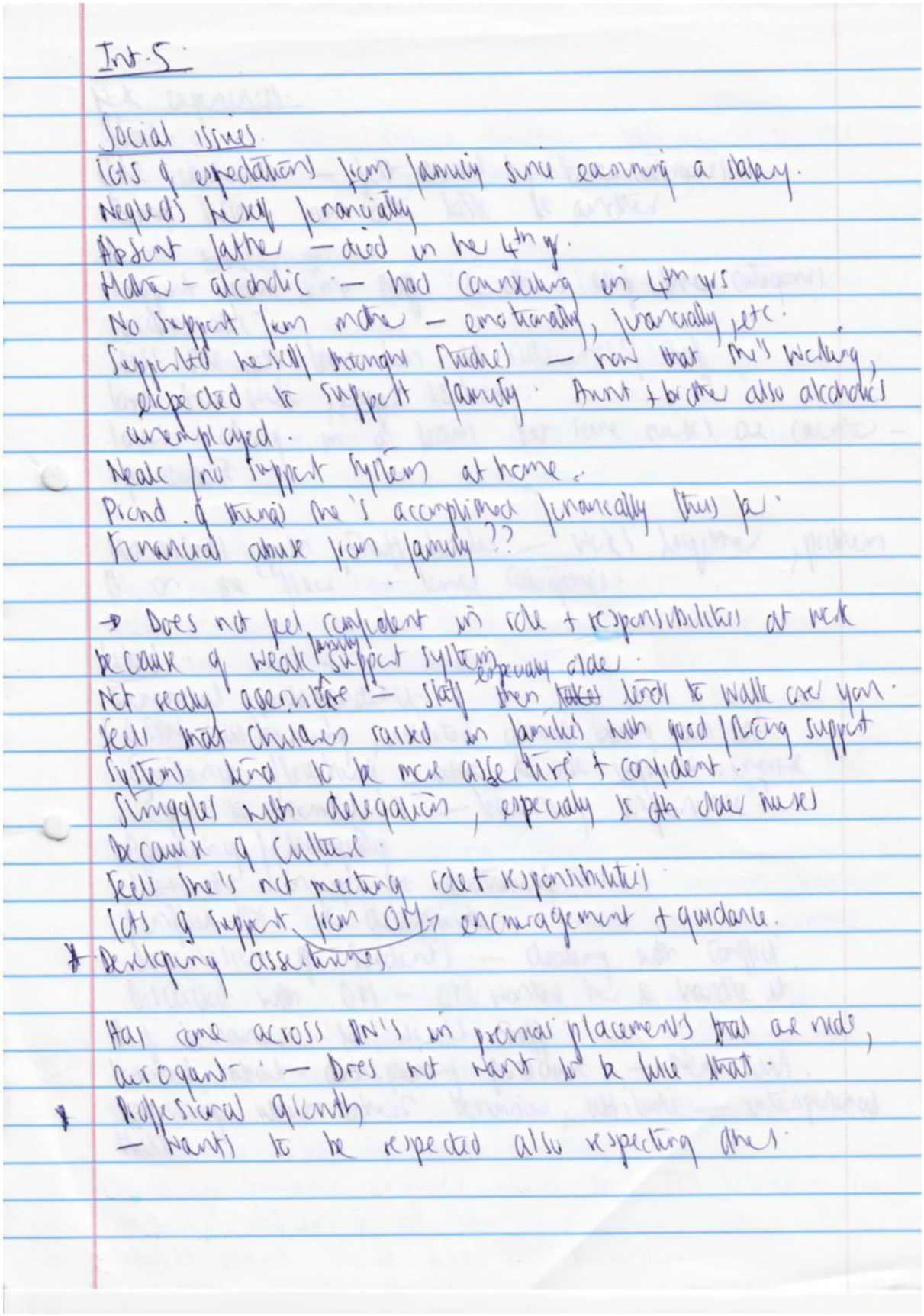
Tell me if there was anything that prevented you from developing your knowledge, practical skills, critical thinking abilities and professional behaviour?

Probes:

- Please tell me more about…
- Why do you think this was such a challenge…?

NOTES:

APPENDIX 8: FIELD NOTES



Int. 5:

Social issues:
Lots of expectations from family since earning a salary.
Neglects home financially
Absent father — died in he 4th yr.
Mother - alcoholic — had counselling in 4th yrs
No support from mother — emotionally, financially, etc.
Supported herself through studies — now that she's working, expected to support family. Aunt + brother also alcoholics unemployed.
Made (no support system at home.
Friend. 4 things she's accomplished financially thus far.
Financial abuse from family??

→ Does not feel confident in role + responsibilities at work because of weak support system, especially older.
Not really assertive — staff often tend to walk over you.
Feel that Christian raised in families with good/strong support systems tend to be more effective + confident.
Struggles with delegation, especially to older nurses because of culture.
Feels she's not meeting role + responsibilities
Lots of support from OM → encouragement + guidance.
* Developing assertiveness

Has come across PN's in previous placements that are rude, arrogant — Does not want to be like that.
* Professional identity
— wants to be respected also respecting others.

Work experiences:
Good.
Clinic incident — felt abused by lower categories
Being taken from one task to another.

Support from some staff + others esp. lower categories) problematic.
Feels she can learn from all categories of staff.
Loves her work, eager to learn.
Loves working in a team but some nurses are counter-productive.

No issues with Staff leader — works together, problem is on the "floor" - lower categories.

Liked.
Financial independency.
(SAN still learning, excited about being an RN.
Guidance / teaching - able to use info to improve (open to corrections) — learning experience
Adapting / changing
Likes the ~~the~~ enjoys the authority
Conflict Mx & delegation
Supervision of students) — dealing with conflict.
Discussed with OM — OM wanted her to handle it
Big behaviour to work staff.
Learned about disciplinary procedure. — New knowledge.
Learning about others behaviour, attitude — interpersonal skills

Social
Obligated to pay tithe to church. — feels church is mck a business, money } now that she'll inherit

Dislike
Other CSWs / friends
Other mck materialistic, life appears good. — feel like she doesn't fit with them anymore
feels she's at a different level to them due to her family responsibilities

~~Less~~ Assisted
Mck hands on compared to ax client.
Able to prioritize ~~he~~ tasks —
Critical thinking — thinks about eg. Able to

Neg behaviour
Recognises bad behaviour — wants to be different + set good example.
Verbal + non verbal communication.
Learned that conflict affects work place, learning, teamwork
Intimed to be assertive — achieves aims — manage the staff.
OM boosts her self-confidence — ± guidance + support
Dislike Other placement had authoritative OM — Shrinking — makes mck rather chaotic
OM wanted her to be mck like OM — but she cannot.
Relief when this OM. gives up duty
Mck performance improves when this OM leaves — no mistakes. Free to be yourself.
Don't want to be like this person.

Assisted

Trained Need more skills — should start in college already
eg. conflict mx, leadership skills as not EPN yet RN

OM to identify gaps in learning — short comings
Being eager to learn, open to new ideas — assists in becoming good RN.
Self-reflection — improvement
Open to discuss short comings + improve on it
Concerned about pt + work after hours — call ward to ensure that one did hand over certain things

Reverted

Social issues
Difficulty with delegation of older tasks — due to their way she was raised (culture)
Cultural upbringing. — affects how people perceive you.
Culture vs profession
Affects pt care — age → young vs old. —
↘ Communication
Decided to ignore culture and act according to profession for the sake of pt care.

2. EPN vs RN
EPN needed before RN.

Useful.

Lots of learning — "groomed"
Building confidence — self-confidence
Financial independence
Cultural awareness — learning about practices of diff cultures

Feels it's ok to make mistakes now while she's (SRN as RN – ~~not~~ will not be easily tolerated
College (theory) different to practical – work
Time to be managed.
Experiences in CSRN preparing to become RN; good stuff learnt
As student not much interested in eg handover, however now as (SRN more involved, enjoy the sharing and learning new knowledge. – Thinking now.
As student cannot question d's on rounds; now critical thinking eg. dr. why ↑ flucon prescribed.
Thought process different now as opposed to student. Thinks critically about things.
Integration of theory + practice
CSRN – best time to learning when RN – no one will be have time to teach you.
Feels [redacted] responsible now for teaching – enjoys learning

Overall demeanor during interview

- Happy, smiling when discussing new role and responsibilities
- "Brave" face when talking about family, father
- "Determined" face when talking about changes re family
- Exasperation → about church, donating money.
- Disgust with behaviour of some nursing staff + manager → determined not to be like that
- Eye-rolling when discussing negative aspects
- Overall excitement of being CSRN and becoming RN

APPENDIX 9: EXTRACT OF TRANSCRIBED INTERVIEW

Interviewer: Tell me more about your, you know, about your knowledge and skills in that sense from being a fourth-year student or going through the four years of training to now. Have you been able to apply those skills, have your skills become better, is there any new skills that you've learned?

Participant: I do apply my skills that they've taught us with this four years it's just that some skills you forget so now you have to now think back and think okay, how do they do it because mostly you like only remember the stuff that you did in fourth year, you know, come to your com-serve year.

And now there's first years, there's second years in my ward and I'm thinking now they're coming to me and now they're asking me, first and second year so now I have to think okay, I know something about that, let me just gou go back.

But I do apply most of the stuff that I was taught, it's just that I think that it depends on the area that you're in.

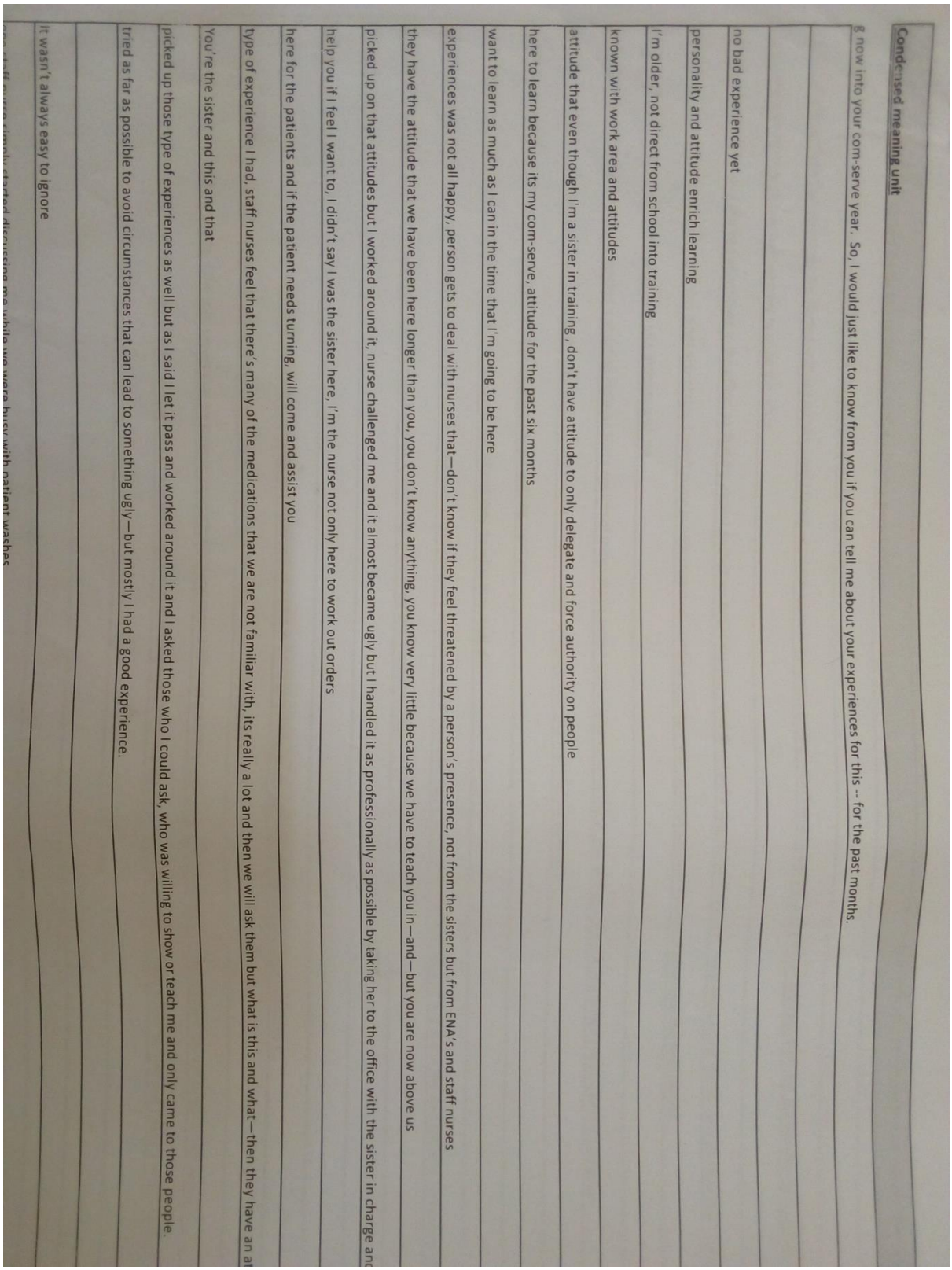
Like I'm in medical right now so mostly it's contact precaution stuff and then also like hanging of the IVs, the IV medication, also the medication itself and then always this, how can I say, evaluating the folders, checking if all the documents are in there and making sure that the staff is actually doing what they're supposed to do with medical.

APPENDIX 10: EXTRACT OF TRANSLATED TRANSCRIBED INTERVIEW

Participant: It—no, it frustrates you but like I say it probably depends on a person's character and what—me as a person if I –if something starts irritating of frustrates me then I verbalise it. I'll go to the sister and say but sister I've had enough now, I'm prepared to learn but I'm not prepared to be abused so it depends. But I discovered that I have a lot of friends of the com-serves that we complain to each other and there's many of them that cannot handle it because they are not bold enough to open their mouths. Like I say, I come from the workplace so I have some type of experience of how to deal with arguments and things inside the workplace but many of them come from school so they don't have a lot of experience about the workplace and it's still a bit difficult for them.

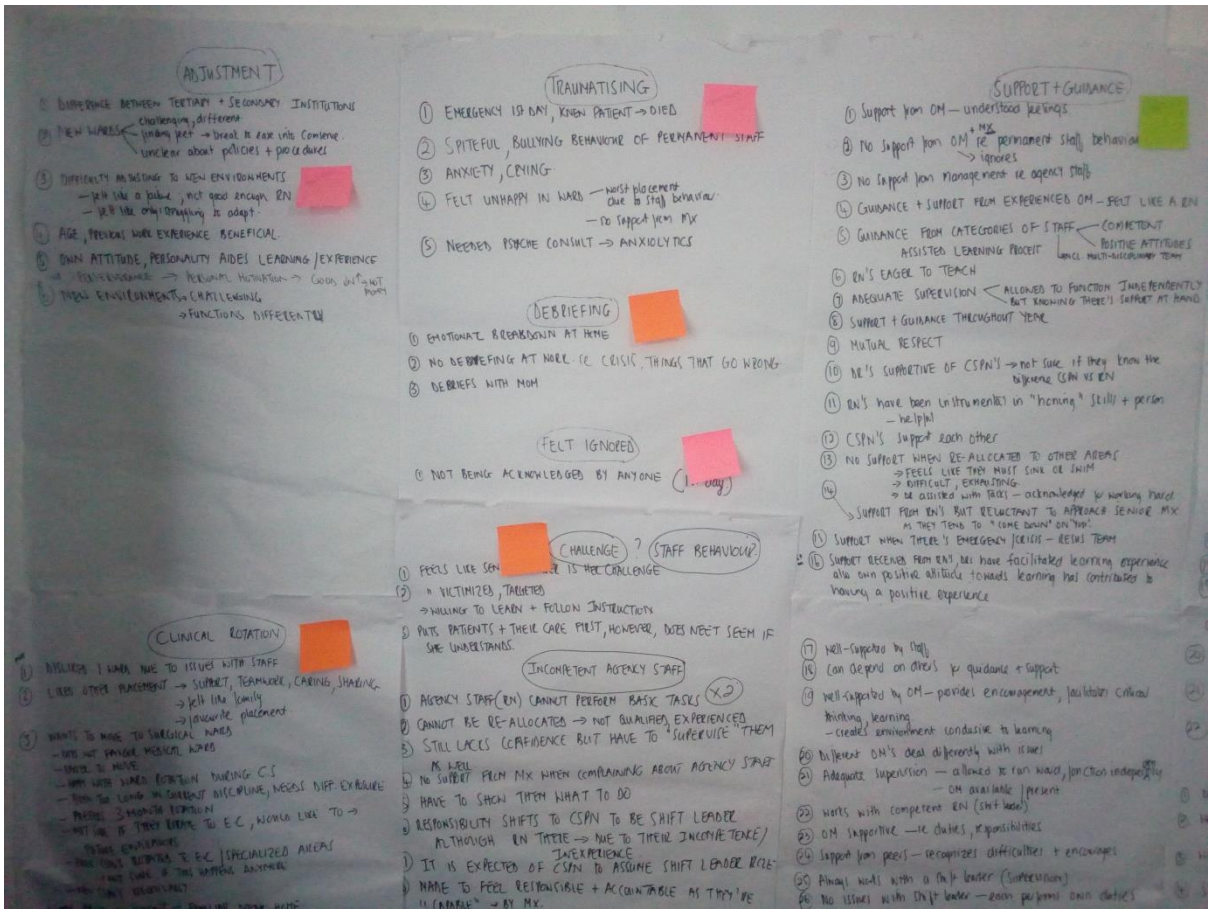
Deelnemer: Dit -- nee, dit frustreer jou maar soos ek sê dit hang maar seker af van die persoon se karakter en wat -- ek is 'n persoon as ek -- as 'n ding my begin irriteer of dit frustrate my dan verbalise ek dit. Ek sal na die sister toe gaan dan sê ek maar sister, ek het nou genoeg gehad, ek is bereid om te leer maar ek is nie bereid om geabuse te raak nie so dit hang maar af. Maar baie het ek geontdek, ek het baie vriende van ons se com-serve dat ons in mekaar -- ons kla by mekaar en daar's baie van hulle wat dit nie kan hanteer nie want hulle is nie bold genoeg om hulle mond oop te maak nie. Soos ek sê ek kom uit die werksplek uit so ek het 'n tipe van experience van hoe om met die twis en goed binne in die werksplekke maar baie van hulle kom van die skool af so hulle is nie baie experienced rondom die werksplek nie so dus nog vir hulle moeilik so.

APPENDIX 11: EXTRACT OF EXCEL DOCUMENT



Condensed meaning unit
g now into your com-serve year. So, I would just like to know from you if you can tell me about your experiences for this -- for the past months.
no bad experience yet
personality and attitude enrich learning
I'm older, not direct from school into training
known with work area and attitudes
attitude that even though I'm a sister in training, don't have attitude to only delegate and force authority on people
here to learn because its my com-serve, attitude for the past six months
want to learn as much as I can in the time that I'm going to be here
experiences was not all happy, person gets to deal with nurses that—don't know if they feel threatened by a person's presence, not from the sisters but from ENA's and staff nurses
they have the attitude that we have been here longer than you, you don't know anything, you know very little because we have to teach you in—and—but you are now above us
picked up on that attitudes but I worked around it, nurse challenged me and it almost became ugly but I handled it as professionally as possible by taking her to the office with the sister in charge and
help you if I feel I want to, I didn't say I was the sister here, I'm the nurse not only here to work out orders
here for the patients and if the patient needs turning, will come and assist you
type of experience I had, staff nurses feel that there's many of the medications that we are not familiar with, its really a lot and then we will ask them but what is this and what—then they have an at
You're the sister and this and that
picked up those type of experiences as well but as I said I let it pass and worked around it and I asked those who I could ask, who was willing to show or teach me and only came to those people.
tried as far as possible to avoid circumstances that can lead to something ugly—but mostly I had a good experience.
It wasn't always easy to ignore

APPENDIX 12: EXTRACT OF FLIPCHART



APPENDIX 13: DECLARATIONS BY LANGUAGE AND TECHNICAL EDITORS

LINGUAFIX

EDITING AND TRANSLATION/REDIGERING EN VERTALING

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www.linguafix.net

19/11/2019

To whom it may concern

Confirmation of language and technical editing

This letter is to record that I have completed a language and technical edit of *Exploring newly qualified nurses' experiences of their compulsory community service year at an urban district hospital* by Vanessa Christina Scheepers.

The edit that I carried out **included** the following:

- Correct grammar, punctuation, spelling and usage
- Attend to the consistency of style, tone and voice
- Point out confusing sentence structures, wrong word choices and ambiguous passages
- Point out incomplete sentences or phrases
- Query or eliminate redundancies and verbosity
- Identify any problems in matters of substance or structure

I did **not**:

- Check bibliographical information for accuracy
- Rearrange sentences, paragraphs or sections to ensure that the argument is logically constructed
- Verify the accuracy of citations
- Verify the accuracy of mathematical or statistical calculations, or specific formulae or symbols, or illustrations
- Verify the correctness or truth of information (unless obvious)

Helena Johanna van Niekerk

M.Diac. (University of South-Africa); Post-graduate Diploma in Editing and Translation (Stellenbosch University)

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